FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-'39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Stoneham (City or town making return)

Registered No. 5

1 PLACE OF DEATH: Middlesex (County); Stoneham (City or Town); No. 114 Franklin St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna Melvina Green nee Dow (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Woodland Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. (Specify whether) In this community yrs. 1 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Walter Green
(Husband's name in full)

6 Age of husband or wife if alive..... years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 1 Months 25 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housework

10 Industry or Business: Own Home

11 Social Security No. None

12 BIRTHPLACE (City) Stoneham (State or country) Massachusetts

PARENTS

13 NAME OF FATHER Andrew J. Dow

14 BIRTHPLACE OF FATHER (City) Warner (State or country) New Hampshire

15 MAIDEN NAME OF MOTHER Cinderilla Noble

16 BIRTHPLACE OF MOTHER (City) Stoneham (State or country) Massachusetts

17 Informant Helen E. White Relation, if any (daughter)
(Address) 45 Honeywell Ave. Brighton, Mass

A TRUE COPY, ATTEST: Winthrop A. McCarthy
(Registrar of city or town where death occurred)

DATE FILED January 10 19 42

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January (Month) 9 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from January 6, 1942, to January 9, 1942

I last saw her alive on January 9, 1942, death is said to have occurred on the date stated above, at 11:30 a.m.

	Duration
Immediate cause of death: Bronchopneumonia	1-6-42
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
.....Date of.....
Of autopsy .....
What test confirmed diagnosis?.....

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) Antonio L. Tauro, M. D.
(Address) Stoneham, Mass. Date 1/9/ 19 42

21 PLACE OF BURIAL, CREMATION OR REMOVAL Lindenwood (Cemetery) Stoneham (City or Town)
DATE OF BURIAL January 11 19 42

22 NAME OF FUNERAL DIRECTOR Charles W. Messer
ADDRESS Stoneham, Mass.

Received and filed January 12 19 42
E. L. Hawkes
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

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50m-10-'39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. 77 Hastings St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Margaret M. Lachapelle (McGrath)
(If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Cordaville Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Benjamin E. Lachapelle
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 68 Years 10 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At Home

11 Social Security No. .....

12 BIRTHPLACE (City) Halifax,
(State or country) Nova Scotia

PARENTS

13 NAME OF FATHER: Michael McGrath

14 BIRTHPLACE OF FATHER (City) Halifax
(State or country) Nova Scotia

15 MAIDEN NAME OF MOTHER: Margaret Lafford

16 BIRTHPLACE OF MOTHER (City) St. Peter's
(State or country) Nova Scotia

17 Informant Mrs. Ruth Muri (Relation, if any) (Niece)
(Address) Framingham, Mass.

A TRUE COPY.
ATTEST: Wm. A. Walsh
(Registrar of city or town where death occurred)

DATE FILED January 27 19 42

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: January (Month) 25 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from November 18, 19 41, to January 25, 19 42

I last saw her alive on Jan. 25, 19 42, death is said to have occurred on the date stated above, at 7:45P m.

Immediate cause of death	Duration
Chronic Rheumatic Heart Disease	3yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) E. F. Regan, M. D.
(Address) Framingham, Mass. Date 1/25 19 42

21 PLACE OF BURIAL, CREMATION OR REMOVAL Immaculate Conception Marlboro
(Cemetery) (City or Town)
DATE OF BURIAL January 28 19 42

22 NAME OF FUNERAL DIRECTOR John J. Brown
ADDRESS Marlboro, Mass.

Received and filed Feb 2 - 1942 19 42
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-'39, No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No.

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Angelo Tomasini (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Woodbury Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution Hospital (Specify whether) years months 7 days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 63 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Laborer

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Italy

PARENTS

13 NAME OF FATHER: Cannot be learned

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER: Cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) Italy

17 Informant (Address) Welfare Records Southboro, Mass. Relation, if any

A TRUE COPY. ATTEST: W. A. Walsh (Registrar of city or town where death occurred)

DATE FILED March 20 19 42

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March (Month) 17 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from March 10, 1942, to March 12, 1942

I last saw h...im...alive on March 17 42, death is said to have occurred on the date stated above, at 4:50P m.

Immediate cause of death	Duration
Cancer of Esophagus	6months
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Date of
Of autopsy
What test confirmed diagnosis?

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) T. J. Carnicelli, M. D.
(Address) Framingham, Mass. Date 3/17 19 42

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural (Cemetery) Southboro (City or Town)
DATE OF BURIAL March 19 19 42

22 NAME OF FUNERAL DIRECTOR Wm. M. Tighe
ADDRESS Marlboro, Mass.

Received and filed 19

(Registrar of City or Town where deceased resided)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m (d)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 2

1 PLACE OF DEATH: Middlesex (County); Southville (City or Town); No. Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Annie Otis (George) Eaton (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Rest Home St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 1 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Frederick W. Eaton
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years 7 Months 15 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: .....

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Haverhill, Mass.

PARENTS

13 NAME OF FATHER Henry Otis George

14 BIRTHPLACE OF FATHER (City) (State or country) Plastow, N. H.

15 MAIDEN NAME OF MOTHER Lois Ann Eaton

16 BIRTHPLACE OF MOTHER (City) (State or country) Haverhill, Mass.

17 Informant Mrs. A. B. Fitts (Address) Framingham, Mass. Relation, if any (daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Telfer
(Signature of Agent of Board of Health or other)
Burial Agent April 7, 1942
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 7 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1941, to April 6, 1942.

I last saw her alive on April 6, 1942 death is said to have occurred on the date stated above, at 12:25 P. m.

Immediate cause of death Pulmonary embolism and cerebral accident — Senile psychosis

Duration — IMPORTANT: 48 hrs. — No cyst.

Due to .....

Due to .....

Other conditions Probable abdominal growth (Include pregnancy within 3 months of death) — 6 mos. IMPORTANT

Major findings: Of operations — Date of .....

Of autopsy —

What test confirmed diagnosis? Physical Exam

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No. If so, specify .....

(Signed) Hilton K. Fenley, M. D.

(Address) 203 Union Ave. Framingham Apr. 7 1942

21 Hilldale Cemetery, Haverhill, Mas
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 8, 1942 19....

22 NAME OF FUNERAL DIRECTOR F. A. Cookson
ADDRESS 318 Union Ave. Framingham

Received and filed ..... 19....
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 3

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southborough.
No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Tilford Franklin Babb (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Main St. (Usual place of abode) (If nonresident, give city or town and state)
Length of stay: In hospital or institution ____ years ____ months ____ days. (Specify whether) In this community 5 yrs. 6 mos. 8 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Ruth Newhall Parker (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of ~~husband~~ or wife if alive 43 years

7 IF STILLBORN, enter that fact here.

8 AGE 46 Years 9 Months 1 Days | If less than 1 day ____ Hours ____ Minutes

9 Usual Occupation: Clerk
10 Industry or Business: Bank

11 Social Security No. 020-14-3051

12 BIRTHPLACE (City) Rochester (State or country) New Hampshire

PARENTS

13 NAME OF FATHER Frank Hamm Babb
14 BIRTHPLACE OF FATHER (City) Strafford (State or country) New Hampshire
15 MAIDEN NAME OF MOTHER Lillian Maria Wentworth
16 BIRTHPLACE OF MOTHER (City) Strafford (State or country) New Hampshire

17 Informant (Address) Ruth N. Babb. Southborough. Relation, if any (wife)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tesler
(Signature of Agent of Board of Health or other)
Burial Agent April 12, 1942
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 11 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from April - 7 -, 1942, to April 11, 1942
I last saw him alive on April 9, 1942, death is said to have occurred on the date stated above, at 6.15 A.m.

	Duration
Immediate cause of death: Coronary occlusion, Uremia and adjacent tissues	2 years
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____ Date of ____
Of autopsy ____
What test confirmed diagnosis? Biopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Roland S. Vaughan, M. D.
(Address) 9 Central Worcester Date Apr 11 1942

21 Mount Auburn Cambridge
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 15, 1942

22 NAME OF FUNERAL DIRECTOR Sumner E. Gage
ADDRESS 15 Cottage Ave., Marlboro

Received and filed ____ 19__

A TRUE COPY ATTEST: (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

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If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m (d)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Boston Rd St. Southboro (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ada {Harvey} Harris (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Boston Rd St. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community 70 yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of James J. Harris
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 87 Years 10 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At Home

10 Industry or Business: .....

11 Social Security No. None

12 BIRTHPLACE (City) South Maitland (State or country) Nova Scotia

PARENTS

13 NAME OF FATHER John Harvey

14 BIRTHPLACE OF FATHER (City) ..... (State or country) Scotland

15 MAIDEN NAME OF MOTHER Nancy Parr

16 BIRTHPLACE OF MOTHER (City) South Maitland (State or country) Nova Scotia

17 Informant Mrs Thomas Connors (Address) Southboro Mass (Relation, if any) Daughter

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Pelfer
(Signature of Agent of Board of Health or other)

Burial Agent April 13. 1942
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 11 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1942 to Apr 11, 1942

I last saw h.er alive on Apr 11, 1942 death is said to have occurred on the date stated above, at 11.50 m.

Immediate cause of death ..... Duration IMPORTANT
Arteriosclerosis ..... 4 yrs.

Due to Chronic Myocarditis ..... 2 yrs.

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

IMPORTANT

Major findings: Of operations None Date of .....

Of autopsy No

What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) E. W. Connelly, M. D.
(Address) Westboro Date 4/13 1942

21 Rural Southboro Mass
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL April 14 1942

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed ..... 19.....

(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

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200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 4

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. Oak Hill Road, Fayville Section St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Barbara Walker (Fennell) McCausland (If U. S. War Veteran specify WAR)

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Oak Hill Road St.
(Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. In this community yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James F. McCausland
(Husband's name in full)

6 Age of husband or wife if alive..... years

7 IF STILLBORN, enter that fact here.

8 AGE 76 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Ireland

PARENTS

13 NAME OF FATHER William Fennell

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Barbara Walker

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Chester Gray, Oak Hill Rd., Fayville (Relation, if any) (Executor of Estate)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tesh
(Signature of Agent, of Board of Health or other)

Burial Agent (Official Designation) April 20, 1942 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 20 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 19, 1942, to April 20, 1942

I last saw h[illegible] alive on April 20, 1942, death is said to have occurred on the date stated above, at 2.55 a. m.

	Duration
Immediate cause of death: Chronic Myocarditis	few years
Myocardial Degeneration	
Due to arteriosclerosis	
Due to	
Other conditions Acute Entero Colitis (Include pregnancy within 3 months of death)	2 days.

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Albert E. Lehuanbe M. D.
(Address) Marlboro Date 4-20 1942

21 Hearse Worcester
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 22 1942

22 NAME OF FUNERAL DIRECTOR Fredrick A. Cookson
ADDRESS Framingham, Mass.

Received and filed ..... 19.....

A TRUE COPY ATTEST: (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m (d)-1-41-4607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 5

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southbro; No. Boston Rd; St. Southboro (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret H Maley (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Boston Rd St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community ..... yrs. ..... mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 87 Years 10 Months 14 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At Home

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Southboro Mass

PARENTS

13 NAME OF FATHER John Maley

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Ellen K Rabbitt

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Joseph O'Reilly Southboro Relation if any (Deputy)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Feeley (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) April 25, 1942 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 25 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1941, to April 25, 1942

I last saw h.. alive on April 18, 1942, death is said to have occurred on the date stated above, at 330 A m.

	Duration
Immediate cause of death: Dehydration	IMPORTANT 3 weeks
Due to: Intestinal obstruction	6 mos
Due to: 3 Cancer	1 yr
Other conditions. (Include pregnancy within 3 months of death): Venous Arteriosclerosis	10 yrs IMPORTANT

Major findings: Of operations ..... Date of .....

Of autopsy ..... What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No. If so, specify .....

(Signed) Hugh Kolseen, M. D.

(Address) Southboro Date April 25 1942

21 Rural Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 27 1942

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed ..... 19.....

(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

1 PLACE OF DEATH: Middlesex (County); Southboro (City or Town); No. Main Street St.

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD
CERTIFICATE OF DEATH

(City or town making return)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME BERTHA RICHARDSON (HUNTER)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If U. S. War Veteran specify WAR)

(a) Residence. No. Main Street St.
(Usual place of abode)
(If nonresident, give city or town and state)
Length of stay: In hospital or institution.---- years months days. In this community yrs. mos. 10 days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of George Richardson
(Husband's name in full)

6 Age of husband or wife if alive 72 years

7 IF STILLBORN, enter that fact here.

8 AGE 67 Years 5 Months 6 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housework

10 Industry or Business:

11 Social Security No. None

12 BIRTHPLACE (City) Stowe
(State or country) Mass.

PARENTS

13 NAME OF FATHER: Hugh Hunter

14 BIRTHPLACE OF FATHER (City) Cannot be learned
(State or country) Scotland

15 MAIDEN NAME OF MOTHER: Cannot be learned

16 BIRTHPLACE OF MOTHER (City) Cannot be learned
(State or country) Scotland

17 Informant (Address) Harold E. Richardson Woburn, Mass. Relation, if any Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Teeler
(Signature of Agent of Board of Health or other)

Agent
(Official Designation)

May 21. 1942
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH MAY (Month) 21 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from MAY 19, 1942, to MAY 21, 1942

I last saw her alive on MAY 21, 1942, death is said to have occurred on the date stated above, at 10.30 a.m.

	Duration
Immediate cause of death: cerebral hemorrhage	1 day
Due to arteriosclerosis	
Due to	
Other conditions carcinoma of liver (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Date of
Of autopsy
What test confirmed diagnosis?

PHYSICIAN
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) David D Shea, M. D.
(Address) 133 Wmain St Date May 21 1942

21 Brookside Stow
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 24, 1942

22 NAME OF FUNERAL DIRECTOR Edward L. Merrill
ADDRESS 1 Pleasant St., Hudson, Mass.

Received and filed 19

A TRUE COPY ATTEST: (Registrar)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 6

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Latisquama Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry Winfield Sawin (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR)

(a) Residence. No. Latisquama Road St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... (Specify whether) years months days. In this community 73 yrs. 5 mos. 25 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Alice Ingalls (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 70 years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years 5 Months 25 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired merchant

10 Industry or Business: Grain business

11 Social Security No. .....

12 BIRTHPLACE (City) Southboro (State or country) Mass.

PARENTS

13 NAME OF FATHER Charles Burleigh Sawin

14 BIRTHPLACE OF FATHER (City) Southboro (State or country) Mass.

15 MAIDEN NAME OF MOTHER Louisa Mae Master

16 BIRTHPLACE OF MOTHER (City) Antrim (State or country) N.H.

17 Informant Alice D. Sawin (Relation, if any Wife) (Address) Latisquama Rd., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Teeles (Signature of Agent of Board of Health or other)

Burial Agent. (Official Designation) June 8, 1942 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June (Month) 7 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May, 1939, to June 7, 1942

I last saw h.... alive on June 7, 1942, death is said to have occurred on the date stated above, at 3.35 p.m.

	Duration
Immediate cause of death: Fibrosarcoma of R. triceps, 1 year	
with metastases to lungs	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
.....Date of.....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) David D. Sher, M. D.

(Address) 133 W. Main St. Date June 7, 1942

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL June 9, 1942

22 NAME OF FUNERAL DIRECTOR Sumner L. Grace
ADDRESS 15 Cutting Ave., Marlboro

Received and filed ..... 19....

A TRUE COPY ATTEST: ..... (Registrar)

COPY OF CERTIFICATE OF DEATH

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
Bureau of the Census

STATE OF NEW HAMPSHIRE

Town or City Clerk's No. _____

FULL NAME Frederick Andrew Carpenter

1. PLACE OF DEATH:

(a) County Cheshire

(b) City or town Keene

(c) Name of hospital or institution: 26 Giffin Street
(If not in hospital or institution write street number or location)

(d) Length of stay:
In hospital or institution _____
(Specify whether years, months or days)
In this community 11 Years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State New Hampshire

(b) County Cheshire

(c) City or town Keene

(d) Street No. 500 Winchester Street
(If rural give location)

(e) If foreign born, how long in U.S.A.? _____ years.

3(a) XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

3(b) If veteran, name war _____

3(c) Social Security No. _____

4. Sex	5. Color or race	6.(a) Single, widowed, married, divorced
Male	White	Married

6.(b) Name of husband or wife:
Abigail Beck
(Full name—Maiden name if wife)

6.(c) Age of husband or wife if alive 64 years.

7. Birth date of deceased November (Month) 16 (Day) 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
66	6	23	_____ hrs. _____ min.

9. Birthplace Keene (City, Town, or County) New Hampshire (State or Foreign Country)

10. Usual occupation Furniture & Antique

11. Industry or business Proprietor

FATHER
12. Name Gregory Carpenter
13. Birthplace - (City, Town, or County) Canada (State or Foreign Country)

MOTHER
14. Maiden name Bridget Lahiff
15. Birthplace - (City, Town, or County) Ireland (State or Foreign Country)

16.(a) Informant's own signature Abigail Carpenter

(b) Address Keene, New Hampshire

17.(a) Removal &Burial (Burial, Cremation, or Removal) (b) Date thereof June (Month) 11 (Day) 1942 (Year)

(c) Place: Burial or cremation Rural Cemetery Southboro, Massachusetts

18.(a) Signature of funeral director Frank J. Foley

(b) Address Keene, New Hampshire

Countersigned Elmer B. Chamberlain
(Agent City Board of Health)

19.(a) June 10, 1942 (Date Received by City Board of Health) (b) June 10, 1942 (Date Received by Town or City Clerk)

Signature of Town or City Clerk Elmer B. Chamberlain, City

Clerk of Keene, New Hampshire

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month June day 8

year 1942 hour 7 minute 15 P.M.

21. I HEREBY CERTIFY that I attended the deceased from Seen As _____, 19____ to _____, 19____;

that I last saw him Medical Referee alive on _____, 19____;
dead

and that death occurred on the date and hour stated above

DURATION

Immediate cause of death Coronary Thrombosis

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

PHYSICIAN

Major findings: Of operations _____

Of autopsy _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or Town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. SIGNATURE J. M. Ballou

M.D. or other M. D. Date signed June 10, 1942

Address Keene, New Hampshire

A true copy, Attest: Elmer B. Chamberlain City Clerk of Keene, N.H., Dated June 10, 1942.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FORM VS. 19A
2-41-5M

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-10-39. No. 8427-i

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southborough (City or Town); No. Boston Rd Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susan Maria Stone (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Boston Road St. ..... (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution No (Specify whether) years months days. In this community 88 yrs. 11 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Edwin Stone (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 91 Years 11 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: .....

10 Industry or Business: At Home

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Framingham Mass

PARENTS

13 NAME OF FATHER Marshall Whitemarsh

14 BIRTHPLACE OF FATHER (City) (State or country) Framingham Mass

15 MAIDEN NAME OF MOTHER Can not be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) " " " "

17 Informant Mrs Thomas Cunners (Address) Boston Rd Southboro Relation, if any (None)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Feeley (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) June 22-1942 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June (Month) 22 (Day) 1942 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Found dead in bed this morning
Cause of death - Sudden - Probably
heart disease hardening of arteries
and senility

20 Accident, suicide, or homicide (specify) .....

Date of occurrence No 19 .....

Where did Injury occur? No (City or town and State)

Did injury occur in or about home, on farm, in industrial place, in public place? — (Specify type of place)

Manner of Injury —

Nature of Injury —

While at work? ..... Was there an autopsy? .....

21 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Frederick Orne Bl, M. D.

(Address) Southboro Mass Date 6-23 1942

22 Rural Cemetery Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL June 23 1942

23 NAME OF FUNERAL DIRECTOR Wm M Tufts

ADDRESS Marlboro Mass

Received and filed ..... 19 .....

(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return) ✓

Registered No. ✓

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town) No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William J. Bagley (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR) Wwii

(a) Residence. No. East Main St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. In this community yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 55 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Meat Cutter

10 Industry or Business: Deerfoot Farm

11 Social Security No. .....

12 BIRTHPLACE (City) Southboro (State or country) Mass

PARENTS

13 NAME OF FATHER Dennis Bagley

14 BIRTHPLACE OF FATHER (City) Southboro (State or country) Mass

15 MAIDEN NAME OF MOTHER May E Lane

16 BIRTHPLACE OF MOTHER (City) Boston (State or country) Mass

17 Informant Mrs Angeline Mitchell (Relation, if any) (Address) East Main St Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Telfer (Signature of Agent of Board of Health or other)

Agent. (Official Designation) 7/9-42 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 7 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 2, 1942, to July 7, 1942

I last saw h.i.m. alive on July 4, 1942, death is said to have occurred on the date stated above, at 7:35 a.m.

	Duration
Immediate cause of death	
Chr. Myocarditis	10 yrs.
Chr. Pleurisy	5 yr.
Due to Cirrhosis Liver	10 yr.
Due to	
Other conditions Chr. Bronchitis (Include pregnancy within 3 months of death)	10 yr.

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Raymond C. Thurber, M. D.

(Address) Marlboro, Mass. Date 7/7 1942

21 Burial Southboro (Place of Burial, Cremation or Removal, (City or Town)

DATE OF BURIAL Friday 7 1942

22 NAME OF FUNERAL DIRECTOR John J. Brown

ADDRESS 90 W Main St Marlboro

Received and filed ..... 19.....

A TRUE COPY ATTEST: ..... (Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. ✓

1 PLACE OF DEATH
Worcester (County)
Southborough (City or Town)
No. Latisquama Rd (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry Williams Young
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(If U. S. War Veteran, specify WAR)

(a) Residence. No. Latisquama Rd St. (Usual place of abode) (If nonresident, give city or town and state)
Length of stay: In hospital or institution .... years months days. In this community 28 yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced HUSBAND of Agnes Hall (Give maiden name of wife in full)
(or) WIFE of .... (Husband's name in full)

6 Age of husband or wife if alive 51 years

7 IF STILLBORN, enter that fact here.

8 AGE 70 Years 9 Months 4 Days. If less than 1 day: Hours Minutes

9 Usual Occupation: Proprietor

10 Industry or Business: grocery store

11 Social Security No.

12 BIRTHPLACE (City) Natick (State or country) Mass

PARENTS

13 NAME OF FATHER: Henry Young

14 BIRTHPLACE OF FATHER (City) Natick (State or country) Mass

15 MAIDEN NAME OF MOTHER: Julia Fairbanks

16 BIRTHPLACE OF MOTHER (City) Hope (State or country) Mass

17 Informant: Mrs Agnes H Young Relation, if any (wife)
(Address) Latisquama Rd. Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

James Teefer
(Signature of Agent of Board of Health or other)
Agent (Official Designation) 7/11-42 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 10 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1942, to July 10, 1942
I last saw him alive on July 9, 1942, death is said to have occurred on the date stated above, at 2:20 P.m.

Immediate cause of death: Mitral Regurgitation — Duration 2-

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations none Date of
Of autopsy none
What test confirmed diagnosis Physical exam

PHYSICIAN Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify.
(Signed) Roland S Newton M. D.
(Address) Westboro Date July 10 1942

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 13 1942

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlboro, Mass.

Received and filed July 22 19

A TRUE COPY ATTEST: (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

100m-10-'39. No. 8427-c

PLACE OF DEATH

1 Worcester (County)

Southboro (City or Town)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No.....

No. Parker St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clara A. O'Neill (nee Varley) (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR).....

(a) Residence. No..... Parker St..... (If nonresident, give city or town and state).
(Usual place of abode) Cordaville

Length of stay: In hospital or institution..... years months days. In this community 53 yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of William O'Neill
(Husband's name in full)

6 Age of husband or wife if alive..... 64 years

7 IF STILLBORN, enter that fact here.

8 AGE 61 Years..... Months..... Days | If less than 1 day Hours..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: .....

11 Social Security No.....

12 BIRTHPLACE (City) Truro
(State or country) Nova Scotia

PARENTS

13 NAME OF FATHER Patrick Varley

14 BIRTHPLACE OF FATHER (City) .....
(State or country) Ireland

15 MAIDEN NAME OF MOTHER Catherine McDonald

16 BIRTHPLACE OF MOTHER (City) .....
(State or country) Nova Scotia

17 Informant William O'Neill Relation, if any (husband)
(Address) Cordaville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Selfe
(Signature of Agent of Board of Health or other)

Agent. 7/17-42
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 16 1942
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1937, to July 16, 1942, last saw h[illegible] alive on July 16, 1942, death is said to have occurred on the date stated above, at 7 P m.

Immediate cause of death..... Duration
Cerebral Thrombosis IMPORTANT 1941

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings :
Of operations .....
Date of.....
Of autopsy .....
What test confirmed diagnosis? Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) [illegible] M. D.
(Address) Westboro Mass. Date July 17 1942

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 20 1942

22 NAME OF FUNERAL DIRECTOR T. H. Callanan & Son
ADDRESS Hopkinton, Mass.

Received and filed..... 19.....
(Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m (d)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Boston Rd Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ellen Goodnow Richards (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Boston Rd St. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community 80 yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Albert Richards
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 89 Years 11 Months 17 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At Home

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

13 NAME OF FATHER James Goodnow

14 BIRTHPLACE OF FATHER (City) Stow (State or country) Mass

15 MAIDEN NAME OF MOTHER Abbie Austins

16 BIRTHPLACE OF MOTHER (City) Stow (State or country) Mass

17 Informant Mr Thomas Connors (Address) Boston Rd Southboro Relation, if any none

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Feeley
(Signature of Agent of Board of Health or other)

Agent 7/17-42
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 17 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 18, 1942, to July 17, 1942.
I last saw her alive on July 16, 1942, death is said to have occurred on the date stated above, at 3.15 a.m.

Immediate cause of death Myocardial's — Duration IMPORTANT 29 days

Due to Arteria Sclerosis — years

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

IMPORTANT

Major findings: Of operations none Date of .....

Of autopsy no

What test confirmed diagnosis? .....

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) E. M. Lynch M. D.
(Address) Southboro Mass Date 7/17 1942

21 Rural Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 19 1942

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed ..... 19 .....
(Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m (d)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Woodland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ida Louise Hinkley (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Woodland Rd St. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 17 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Widow

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Thomas Franklin Hinkley
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here. —

8 AGE 88 Years 0 Months 0 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Home

10 Industry or Business: —

11 Social Security No. —

12 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS

13 NAME OF FATHER Rufus Gitts

14 BIRTHPLACE OF FATHER (City) (State or country) Plymouth Mass

15 MAIDEN NAME OF MOTHER Louisa Davis

16 BIRTHPLACE OF MOTHER (City) (State or country) England

17 Informant Ralph T. Hinkley (Relation, if any Son)
(Address) Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Feeley
(Signature of Agent of Board of Health or other)
Burial Agent Aug 3, 1942
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH August (Month) 2 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1941, to Aug 2, 1942
I last saw her alive on Aug 1, 1942 death is said to have occurred on the date stated above, at 1 05 A.m.

Duration — IMPORTANT

Immediate cause of death
Dehydration — 1 wk

Due to Diarrhea — 1 wk

Due to Gen. Arteriosclerosis — 10 yrs
Chronic nephritis — 10 yrs

Other conditions (Include pregnancy within 3 months of death)

IMPORTANT — Physician — Underline the cause to which death should be charged statistically.

Major findings: Of operations none
Date of .....
Of autopsy none
What test confirmed diagnosis? .....

20 Was disease or injury in any way related to occupation of deceased? No. If so, specify .....
(Signed) Hugh F. Falconer M. D.
(Address) 19 Summer Ave Framingham Mass Date Aug 3 1942

21 Forest Hills Framingham Boston Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Aug 5 1942

22 NAME OF FUNERAL DIRECTOR F. H. Cookson
ADDRESS Framingham, Mass

Received and filed Aug 4 11 1942 19 .....
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

100m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return) ✓

Registered No. .....

1 PLACE OF DEATH: (County) Worcester (City or Town) Southbridge No. Parkerville Rd Southville St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Cecelia Chichenning (If deceased is a married, widowed or divorced woman, give also maiden name.) wife Tennessen (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Parkerville Rd Southville St. (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 50 yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
female	white	widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Frank J Chichenning (Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE	Years	Months	Days	If less than 1 day: Hours	Minutes
	88	11			

9 Usual Occupation: at Home

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) Freeport (State or country) Maine

PARENTS

13 NAME OF FATHER Joseph Pennerson

14 BIRTHPLACE OF FATHER (City) ..... (State or country) Can not be learned

15 MAIDEN NAME OF MOTHER Caroline Blackstrom

16 BIRTHPLACE OF MOTHER (City) ..... (State or country) Can not be learned

17 Informant (Address) Mrs Charles Sibley Parkerville Rd Southville (Relation, if any) Sister-in-law

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Feeley
(Signature of Agent of Board of Health or other)

Agent (Official Designation) Sept 14, 1942 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Sept (Month) 16 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1942, to Sept 16, 1942
I last saw h.e alive on Sept 16, 1942, death is said to have occurred on the date stated above, at 12 p.m.

	Duration
Immediate cause of death: Myocardial Insufficiency	2 -
Due to Arteriosclerosis Chronic	2 -
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN: Underline the cause to which death should be charged statistically.

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis Physical exam

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) Richard O Wareham M. D.
(Address) Central Worthington Date Sept 16 1942

21 Burial Southville
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL (Sept 20 1942

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed Sept 12 1942

A TRUE COPY ATTEST: (Registrar)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-10-39. No. 8427-i

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. 1 Flagg Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward C Wells (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. 1 Flagg Road St. ..... (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 40 yrs. 6 mos. ..... days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of: Rose L. Walcott
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive: 66 years

7 IF STILLBORN, enter that fact here.

8 AGE: 66 Years 9 Months 6 Days | If less than 1 day: Hours ..... Minutes

9 Usual Occupation: Farmer

10 Industry or Business: Farming

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country): Natick Mass.

PARENTS

13 NAME OF FATHER: Edward B. Wells

14 BIRTHPLACE OF FATHER (City) (State or country): Nova Scotia

15 MAIDEN NAME OF MOTHER: Martha L. ~~White~~ Z. Wight

16 BIRTHPLACE OF MOTHER (City) (State or country): Natick Mass.

17 Informant (Address): Rose L. Wells Flagg Rd., Southboro — Relation, if any: (Wife)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Felter
(Signature of Agent of Board of Health or other)

Burial Agent. Oct. 4. 1942
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Oct (Month) 3 (Day) 1942 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19.....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, in public place? .....
(Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? ..... Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Walter F Whitney M. D.

(Address) Westboro Mass. Date Oct 3 19 42

22 Rural Cemetery Place of Burial, Cremation or Removal. Southboro (City or Town)

DATE OF BURIAL October 5 19 42

23 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS Marlboro Mass.

Received and filed Oct 10 19 42

(Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m (d)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Burlington (County) — New Hanover (City or Town) — No. Fort Dix Station Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles C. Lowell
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) WW I WW 2

(a) Residence. No. 6 Clarendon St. Natick, Mass. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widower

5a If married, widowed, or divorced
HUSBAND of Gladys Troop
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 45 Years 3 Months 29 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: meat cutter

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

13 NAME OF FATHER: Hiram Austin

14 BIRTHPLACE OF FATHER (City) (State or country) Southboro, Mass.

15 MAIDEN NAME OF MOTHER: Mary Emma Claflin

16 BIRTHPLACE OF MOTHER (City) (State or country) Southboro, Mass.

17 Informant Lowell W. Lowell (Address) 73 Water St. Saxonville (Relation, if any) brother

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Teeter
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation)

Oct 16 1942 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH October 13, 1942
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct 12th, 19 42, to Oct. 13, 19 42
I last saw him alive on Oct. 13, 19 42, death is said to have occurred on the date stated above, at 11.40 P m.

Immediate cause of death acute massive hemorrhage due to ruptured varices of the stomach — Duration IMPORTANT

Due to as above

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations ..... Date of .....

Of autopsy as above

What test confirmed diagnosis? .....

IMPORTANT Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Isadore Cohen Ft. Dix M. D.
(Address) Station Hospital Date Oct 13 1942

21 Rural Cemetery - Southboro, Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Oct. 17, 1942 19

22 NAME OF FUNERAL DIRECTOR F. A. Cookson
ADDRESS 318 Union Ave. Framingham

Received and filed ..... 19 .....
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southbridge; No. Prentiss St St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lizzie E (Prentiss) Hyde (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR)

(a) Residence. No. Prentiss St Southbridge St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Edmund A Hyde (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 84 Years 1 Months 10 Days | If less than 1 day Hours Minutes

9 Usual Occupation:

10 Industry or Business: At Home

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Southbero

PARENTS

13 NAME OF FATHER Benjiman F. Prentiss

14 BIRTHPLACE OF FATHER (City) (State or country) Hopkinton Mass

15 MAIDEN NAME OF MOTHER Susan S Johnson

16 BIRTHPLACE OF MOTHER (City) (State or country) Can not be learned

17 Informant (Address) Mrs Albert Beaton Prentiss St Southville Relation, if any (Daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Leeler
(Signature of Agent of Board of Health or other)
Burial Agent. Nov. 4. 1942
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov (Month) 2 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Nov, 1938, to Nov 2, 1942

I last saw h.er alive on Nov 2, 1942, death is said to have occurred on the date stated above, at 10.30 p.m.

	Duration
Immediate cause of death: Uremia	2 days
Due to Chronic Nephritis	10 yrs
Due to Hypertension & arteriosclerosis	20 yrs
Other conditions (Include pregnancy within 3 months of death) Probable Ovarian Cyst	3 mos

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Thos F Glenn, M. D.
(Address) Southbero Date Nov 3 1942

21 Rural Southbero
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov 5 1942

22 NAME OF FUNERAL DIRECTOR Wm M Fiske
ADDRESS Marlboro Mass

Received and filed ..... 19.....

A TRUE COPY ATTEST: (Registrar)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

Southboro (City or town making return)

Registered No. 1865

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Parkerville Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles H. Morin (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR)

(a) Residence. No. Parkerville Rd. St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Amelia Brodeur Morin (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 66 years

7 IF STILLBORN, enter that fact here.

8 AGE 76 Years 11 Months 4 Days; If less than 1 day Hours ..... Minutes

9 Usual Occupation: Retired

10 Industry or Business: Shoe Worker

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Shrewsbury Mass

PARENTS

13 NAME OF FATHER Charles Morin

14 BIRTHPLACE OF FATHER (City) (State or country) Canada

15 MAIDEN NAME OF MOTHER Marie Suprenant

16 BIRTHPLACE OF MOTHER (City) (State or country) Middlebov Vermont

17 Informant Mrs C. H. Morin (Address) Parkerville Rd. Southb (Relation, if any) Wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Teller (Signature of Agent of Board of Health or other)

Burial Agent Nov. 3. 1942. (Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 2 1942 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1939, to Nov. 2, 1942

I last saw h. alive on Nov. 1, 1942, death is said to have occurred on the date stated above, at 5:12 p.m.

	Duration
Immediate cause of death: Arteriosclerosis	
Chronic Myocarditis	1939
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Albert E. LeMaitre M. D.
(Address) Marlboro Date Nov. 2 1942

21 Southborough Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov 5-6 1942

22 NAME OF FUNERAL DIRECTOR Buisson & Morin
ADDRESS 32 Cross St. Marlboro

Received and filed Nov. 17 19....

A TRUE COPY ATTEST: Chas F. Marshall (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

RUTLAND (City or town making return)

Registered No. 210

1 PLACE OF DEATH: WORCESTER (County); RUTLAND (City or Town); No. Rutland State Sanatorium St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank Bassett (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Gilmore Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Sanatorium (Before death) (Specify whether) years --- months --- days. In this community --yrs. --mos. --days.
9½ hours 9½ hours

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced HUSBAND of Louella Green (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 70 years

7 IF STILLBORN, enter that fact here.

8 AGE 72 Years 7 Months 17 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Manufacturer

10 Industry or Business: Lighting fixtures

11 Social Security No. ---

12 BIRTHPLACE (City) (State or country) Brewster, Mass.

PARENTS

13 NAME OF FATHER: Thaddeus Bassett

14 BIRTHPLACE OF FATHER (City) (State or country): Brewster, Mass.

15 MAIDEN NAME OF MOTHER: Mary Dorn

16 BIRTHPLACE OF MOTHER (City) (State or country): Brewster, Mass.

17 Informant (Address): State San. Records, Rutland, Mass. (Relation, if any)

A TRUE COPY.
ATTEST: Frances P. Hanff (Registrar of city or town where death occurred)
DATE FILED November 4, 1942 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: November (Month) 4, (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from November 3, 1942, to November 4, 1942.
I last saw him alive on November 4, 1942 death is said to have occurred on the date stated above, at 12:30 A.M.

	Duration
Immediate cause of death: Pulmonary tuberculosis	Unkn.
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: Date of
Of autopsy:
What test confirmed diagnosis? X-ray

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify Unknown

(Signed) Armand Laroche, M. D.
(Address) Rutland State San. Date 11/4 1942

21 PLACE OF BURIAL, CREMATION OR REMOVAL Maple Grove, Westport (Cemetery) (City or Town) Mass
DATE OF BURIAL November 8, 1942 19

22 NAME OF FUNERAL DIRECTOR H. W. Brightman
ADDRESS No. Westport, Mass.

Received and filed 12-5 19
(Registrar of City or Town where deceased resided)

FORM R-305

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-10-39. No. 8427-g

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No.

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Julia M. Kelley (nee Calnan)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(If U. S. War Veteran, specify WAR)

(a) Residence. No. Highland Road St. Southboro
(Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution Hospital (Specify whether) years 1 months 7 days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Daniel F. Kelley (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 81 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: At home

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) Marlboro (State or country) Mass.

PARENTS

13 NAME OF FATHER John Calnan

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Mary Ambrose

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant Robert Kelley (Relation, if any Son)
(Address) Cordaville, Mass.

A TRUE COPY. Wm. A. Walsh
ATTEST: (Registrar of city or town where death occurred)

DATE FILED November 18, 1942 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 16, 1942
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture of femur (left)
Senility

20 Accident, suicide, or homicide (specify)
Date of occurrence October 9, 1942 19
Where did Injury occur? Cordaville, Mass.
(City or town and State)

Did injury occur in or about the home, on farm, in industrial place, or in public place? Home
(Specify type of place)

Manner of Injury Fall

Nature of Injury Fracture of neck of femur

While at work? No Was there an autopsy? View

21 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Michael F. Burke
(Address) Natick, Mass. Date 11/16/42 M. D.

22 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL November 18, 1942 19

23 NAME OF FUNERAL DIRECTOR T.F. Callanan & Son
ADDRESS Hopkinton, Mass.

Received and filed Nov-23 19
(Registrar of City or Town where deceased resided)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return) ✓

Registered No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eleanor (Turnbull) Telfer (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR)

(a) Residence. No. East Main St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. In this community 41 yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James J. Telfer
(Husband's name in full)

6 Age of husband or wife if alive..... years

7 IF STILLBORN, enter that fact here.

8 AGE 82 Years 3 Months 0 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No. .....

12 BIRTHPLACE (City) Gateshead (State or country) Newcastle on Tyne, England

PARENTS

13 NAME OF FATHER William Turnbull

14 BIRTHPLACE OF FATHER (City) ..... (State or country) Scotland

15 MAIDEN NAME OF MOTHER Margaret Dalgleish

16 BIRTHPLACE OF MOTHER (City) ..... (State or country) Scotland

17 Informant Margaret Teller Relation, if any Daughter
(Address) East Main St Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Teeter
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Dec 6, 1942 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec (Month) 4 (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 27, 1935, to Dec 4, 1942

I last saw h[illegible] alive on Dec 3, 1942, death is said to have occurred on the date stated above, at 3.30 A.m.

	Duration
Immediate cause of death: Myocardial disease Chronic	10 years
Due to Arterio sclerosis Chronic	-3-
Due to	
Other conditions (Include pregnancy within 3 months of death) Hypertension Congenital	1922

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? Physical exam

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) Conrad J Mansfield, M. D.
(Address) 6 Main St Date 12/4 1942

21 Burial Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL December 7, 1942

22 NAME OF FUNERAL DIRECTOR Gunnery E. Gage
ADDRESS 15 Collins Ave., Marlboro

Received and filed Dec 12 - 1942 19.....

A TRUE COPY ATTEST: [signature] (Registrar)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-10-'39. No. 8427-i

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. V

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Highland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert W. Schnare (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Highland Road St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution ..... (Specify whether) years months days. In this community 40 yrs. 3 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of: Frances Leary (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 64 years

7 IF STILLBORN, enter that fact here.

8 AGE 81 Years 6 Months 14 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Freight agent (Retired)

10 Industry or Business: B & W. Electric Railway

11 Social Security No. None

12 BIRTHPLACE (City) (State or country): St. Margarets Bay, Halifax Co., Nova Scotia

PARENTS

13 NAME OF FATHER: James Schnare

14 BIRTHPLACE OF FATHER (City) (State or country): Black Point, Halifax Co., Nova Scotia

15 MAIDEN NAME OF MOTHER: Amelia Walker

16 BIRTHPLACE OF MOTHER (City) (State or country): Black Point, Halifax Co., Nova Scotia

17 Informant (Address): Frances Schnare, Highland Road, Southboro (Relation, if any: Wife)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Teeter (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) December 27-42 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Dec (Month) 27 (Day) 1942 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic Heart Disease

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? No Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter F. Mahoney, M. D.

(Address) Westborough Date Dec 27 1942

22 Rural Cemetery, Southboro Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL December 1942

23 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS 135 Cutting Ave., Marlboro, Mass.

Received and filed ..... 19 .....

(Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 1

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Break Neck Hill St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Kate (Paine) Seaton (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) ____

(a) Residence. No. Break Neck Hill St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ____ years ____ months ____ days. (Before death) (Specify whether) In this community 16 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: W | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of ____ (or) WIFE of Harry F. Seaton (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ____ years

7 IF STILLBORN, enter that fact here. ____

8 AGE 68 Years 1 Months 2 Days | If less than 1 day ____ Hours ____ Minutes

9 Usual Occupation: Home

10 Industry or Business: ____

11 Social Security No. ____

12 BIRTHPLACE (City) (State or country) Seaver England

PARENTS

13 NAME OF FATHER George Paine

14 BIRTHPLACE OF FATHER (City) (State or country) Seaver England

15 MAIDEN NAME OF MOTHER Unknown

16 BIRTHPLACE OF MOTHER (City) (State or country) Seaver England

17 Informant Fred Seaton (Relation, if any) Son (Address) 113 State Rd. Swampscott

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Fetter (Signature of Agent of Board of Health or other)

Burial Agent December 27-42 (Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec. 27 (Month) (Day) 1942 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1942, to Dec. 27, 1942

I last saw h[illegible] alive on Dec. 24, 1942, death is said to have occurred on the date stated above, at 10:00 A.m.

	Duration
Immediate cause of death: General Cerebral Sclerosis	1 hrs.
Chronic Myocarditis	2 yrs.
Due to Hypertension Heart Disease	2 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

IMPORTANT

Major findings: Of operations ____ Date of ____ Of autopsy ____ What test confirmed diagnosis? ____

IMPORTANT Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No. If so, specify ____

(Signed) R. A. Johnson, M. D.

(Address) Marlboro, Mass. Date 12/27 1942

21 Swampscott / Swampscott (Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Dec 29 1942

22 NAME OF FUNERAL DIRECTOR H. L. Richardson

ADDRESS 48 Lafayette Park, Lynn

Received and filed ____ 19____ (Registrar)

FORM R-305

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m (h)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Westborough
(City or town making return)

Registered No. 13

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town); No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nora M. Gebhart (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence, No. Newton St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution 15 years 9 months 18 days. (Before death) (Specify whether) In this community 27 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced
HUSBAND of Joseph Gebhart (Wife's maiden name in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 48 years

7 IF STILLBORN, enter that fact here.

8 AGE 46 Years 10 Months 8 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Ireland

PARENTS

13 NAME OF FATHER: Michael O'Connor

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Mary Coffey

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address) Westborough State Hospital records (Relation, if any)

A TRUE COPY.
ATTEST: Annie A. Dunne
(Registrar of city or town where death occurred)
DATE FILED Jan. 14, 1943

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January (Month) 11, (Day) 1943 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Septic Parotitis with cellulitis,
Fatty degeneration of heart

20 Accident, suicide, or homicide (specify)
Date of occurrence 19
Where did Injury occur? (City or town and State)
Did injury occur in or about the home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury
Nature of Injury
While at work? Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? yes
If so, specify
(Signed) Walter F. Mahoney M. D.
(Address) Westborough Date 1/11, 19 43

22 Place of Burial, Cremation or Removal. Rural (City or Town) Southboro
DATE OF BURIAL 19

23 NAME OF FUNERAL DIRECTOR John J. Brown
ADDRESS 952 Main St., Marlboro

Received and filed 19
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Paul Sumner Lincoln (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Wood St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution..... years months days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced HUSBAND of Clara Isota Hill (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 84 years

7 IF STILLBORN, enter that fact here.

8 AGE 84 Years 3 Months 25 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Postmaster

10 Industry or Business: Post Office and Gen. Store

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Acton Mass.

PARENTS

13 NAME OF FATHER: Caleb Lincoln

14 BIRTHPLACE OF FATHER (City) (State or country): Cochituate Mass.

15 MAIDEN NAME OF MOTHER: Jane Reed

16 BIRTHPLACE OF MOTHER (City) (State or country): Littleton Mass.

17 Informant (Address) Howard R. Lincoln (Relation, if any) Son Pearl St. Southville

A TRUE COPY.
ATTEST: W. A. Walsh
(Registrar of city or town where death occurred)
DATE FILED Feb. 16, 1943

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: February (Month) 11 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1943, to Feb. 11, 1943
I last saw him alive on Feb. 11, 1943, death is said to have occurred on the date stated above, at 2:00 p. m.

	Duration
Immediate cause of death: Uremia	5 days
Due to: Urinary Obstruction	1 yr.
Due to:	
Other conditions: Hypertensive heart dis. (Include pregnancy within 3 months of death)	

Major findings:
Of operations..... Date of .....
Of autopsy.....
What test confirmed diagnosis?.....

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Hugh Folson, M. D.
(Address) 198 Union Ave. Date 2/12 1943

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Rural - Southville (Cemetery) (City or Town)
DATE OF BURIAL Feb. 14 1943

22 NAME OF FUNERAL DIRECTOR: Vernon E. Morrill
ADDRESS 15 Church St., Hopkinton

Received and filed February 16 1943
(Registrar of City or Town where deceased resided)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-10-'39. No. 8427-i

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No.....

1 PLACE OF DEATH: Middlesex (County); Southboro (City or Town)

No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sarah A. Brett Leighton (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR).....

(a) Residence. No. 15 Grove St. Hopkinton, Mass. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution Rest home (Specify whether) years months 14 days. In this community 20 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of James Leighton
(Husband's name in full)

6 Age of husband or wife if alive.....years

7 IF STILLBORN, enter that fact here.

8 AGE 98 Years 2 Months Days | If less than 1 day: Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: Own home

11 Social Security No.....

12 BIRTHPLACE (City) (State or country) Portland Maine

PARENTS

13 NAME OF FATHER Ira Brett

14 BIRTHPLACE OF FATHER (City) (State or country) Unknown

15 MAIDEN NAME OF MOTHER Mary King

16 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

17 Informant Mrs. Millie C. Thayer Relation, if any (.....)
(Address) 15 Grove St., Hopkinton, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Kelley
(Signature of Agent of Board of Health or other)

Agent. Feb. 15, 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb (Month) 14 (Day) 1943 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arterio Sclerotic heart disease

20 Accident, suicide, or homicide (specify).....

Date of occurrence.....19.....

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, in public place?..... (Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work?.....Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter F Mahoney M. D.

(Address) Westborough Date 2/14 1943

22 Mt. Auburn Cemetery, Hopkinton, Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Feb. 18 19 43

23 NAME OF FUNERAL DIRECTOR Vernon E. Morrill
ADDRESS 15 Church St. Hopkinton, Mass.

Received and filed.....19.....

(Registrar)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return) ✓

Registered No.....

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Wood St Southville St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susan E Mann Sanders (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR).....

(a) Residence. No. Wood St St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. (Specify whether) In this community 30 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of George A Sanders
(Husband's name in full)

6 Age of husband or wife if alive..... years

7 IF STILLBORN, enter that fact here.

8 AGE 89 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation:

10 Industry or Business: at Home

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Lowell Mass

PARENTS

13 NAME OF FATHER Jewett Mann

14 BIRTHPLACE OF FATHER (City) (State or country) Barre Vermont

15 MAIDEN NAME OF MOTHER Nellie Mason

16 BIRTHPLACE OF MOTHER (City) (State or country) Swanzey N. H.

17 Informant (Address) Charles B Jones 7 Elm Place Framingham Relation, if any Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Feeley
(Signature of Agent of Board of Health or other)
Agent Oct 15, 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Oct (Month) 15 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct 1, 19.43, to Oct 15, 19.43

I last saw her alive on Oct 14, 19.43, death is said to have occurred on the date stated above, at 3 A m.

Duration
Immediate cause of death: Generalized Sclerosis
Cortical Sclerosis heart disease — weeks
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....

Major findings:
Of operations .....
.....Date of.....
Of autopsy .....
What test confirmed diagnosis? Stethoscope

PHYSICIAN
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) Walter F Mahoney, M. D.
(Address) Westboro Date Oct 16 1943

21 Burial Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Oct 17 1943

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed..... 19.....

A TRUE COPY ATTEST: (Registrar)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-2-'40-D-729-b

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No.....

1 PLACE OF DEATH: Worcester (County); Southbury (City or Town); No. Southville Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Asdell D Stone (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR).....

(a) Residence. No. Southville Rd St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution — (Specify whether) — years — months — days. In this community 20 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
female	white	widowed

5a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Irving M. Stone
(Husband's name in full)

6 Age of husband or wife if alive 62 years

7 IF STILLBORN, enter that fact here.

8 AGE 87 Years 11 Months 10 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife own Home

10 Industry or Business: —

11 Social Security No. none

12 BIRTHPLACE (City) Hampden (State or country) Maine

PARENTS

13 NAME OF FATHER James Stone

14 BIRTHPLACE OF FATHER (City) Hampden (State or country) Maine

15 MAIDEN NAME OF MOTHER Dorothy Weeks

16 BIRTHPLACE OF MOTHER (City) cannot be learned (State or country) cannot be learned

17 Informant Mildred L Stone (Relation, if any Daughter)
(Address) Southville Rd Southbury Conn

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Lefler
(Signature of Agent of Board of Health or other)

Agent March 5 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 3 1943
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Arteriosclerotic heart disease

20 Accident, suicide, or homicide (specify).....
Date of occurrence.....19.....

Where did Injury occur?.....
(City or Town and State)

Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)

Manner of Injury.....

Nature of Injury.....

While at work? no Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter F McInerney, M. D.

(Address) Westbrook Date Mar 3 1943

22 Interment Hampden Maine
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 7 1943

23 NAME OF FUNERAL DIRECTOR Irving M Hayden

ADDRESS 62 Main St Southbury Conn

Received and filed March 9 1943

E M Ramsdell
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 3427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return) ✓

Registered No.....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Adelaide Louise Wrye (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR).....

(a) Residence. No. Main St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. In this community 5 yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive..... years

7 IF STILLBORN, enter that fact here.

8 AGE 68 Years 10 Months 8 Days | If less than 1 day Hours Minutes

9 Usual Occupation: At home

10 Industry or Business:

11 Social Security No. .....

12 BIRTHPLACE (City) Jacksonville (State or country) New Brunswick

PARENTS

13 NAME OF FATHER William Wrye

14 BIRTHPLACE OF FATHER (City) ——— (State or country) New Brunswick

15 MAIDEN NAME OF MOTHER Arabella Ingalls

16 BIRTHPLACE OF MOTHER (City) ——— (State or country) New Brunswick

17 Informant Wallace M. Wrye (Address) Main St., Southboro Relation if any (Brother)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James J. Tobin
(Signature of Agent of Board of Health or other)

Agent March 5, 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 3 1943 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1943 to Mar. 3, 1943

I last saw h[illegible] alive on Mar 2, 1943, death is said to have occurred on the date stated above, at 6 A.M.

Immediate cause of death	Duration
Myocardial Insufficiency	1
Due to	
Due to	
Other conditions ——— (Include pregnancy within 3 months of death)	

Major findings:
Of operations ———
Date of.....
Of autopsy ———
What test confirmed diagnosis?

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify.....

(Signed) Roland J. Hamilton M. D.
(Address) Medical Building Date Mar 3 1943

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 6, 1943

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15 Cutting Ave., Marlboro, Mass.

Received and filed March 9 1943

A TRUE COPY ATTEST: (Registrar)

FORM R-301 A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. ....

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. 3 Wood St St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Theodore Olson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) ....

(a) Residence. No. Wood St. Southborough
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution .... years months days. In this community yrs. 9 mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced HUSBAND of Helen F. Wright
(Give maiden name of wife in full)
(or) WIFE of ....
(Husband's name in full)

6 Age of husband or wife if alive 65 years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years .... Months .... Days. If less than 1 day .... Hours .... Minutes

9 Usual Occupation: Rubber Worker Supt.

10 Industry or Business: Retired

11 Social Security No. 018-09-2337

12 BIRTHPLACE (City) (State or country) Sweden

PARENTS

13 NAME OF FATHER Oscar Olson

14 BIRTHPLACE OF FATHER (City) (State or country) Sweden

15 MAIDEN NAME OF MOTHER unknown

16 BIRTHPLACE OF MOTHER (City) (State or country) unknown

17 Informant Mrs T. Olson (Relation, if any: wife)
(Address) 3 Wood St

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
James F. Telfer
(Signature of Agent of Board of Health or other)
Agent (Official Designation) March 8, 1943 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March (Month) 8 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July, 1942, to Mar 8, 1943,
I last saw him alive on Mar 8, 1943, death is said to have occurred on the date stated above, at 3 P. m.

Immediate cause of death: Carcinoma prostate gland — Duration: 9 years (IMPORTANT)

Due to ....

Due to ....

Other conditions (Include pregnancy within 3 months of death) ....

IMPORTANT Physician: Underline the cause to which death should be charged statistically.

Major findings:
Of operations .... Date of 1940
Of autopsy none
What test confirmed diagnosis? biopsy

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify ....
(Signed) Roland C. Newton, M. D.
(Address) 9 Common St Watertown Date Mar 8 1943

21 Ridgelawn Watertown
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Mar. 11 1943

22 NAME OF FUNERAL DIRECTOR Geo. H. Gregg & Son
ADDRESS Watertown Mass

Received and filed 1943
(Registrar)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Blanche Irene (Bennett) Thompson (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. 14 Maple St. Fayville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Hospital years months 4 days. In this community yrs. mos. days. (Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Charles H. Thompson (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 69 Years 5 Months 26 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housework

10 Industry or Business: own home

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) St. John New Brunswick

PARENTS

13 NAME OF FATHER: Edward B. Bennett

14 BIRTHPLACE OF FATHER (City) Saint John (State or country) New Brunswick

15 MAIDEN NAME OF MOTHER: Rosanna Pelton

16 BIRTHPLACE OF MOTHER (City) St. John (State or country) New Brunswick

17 Informant Mrs. Arthur Gustin (Relation, if any) niece
(Address) 11 Brookfield Rd., Waltham, Mass

A TRUE COPY.
ATTEST: .....
(Registrar of city or town where death occurred)

DATE FILED March 15 1943

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March (Month) 11 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from March 8, 1943, to March 11, 1943.
I last saw her alive on March 11, 1943 death is said to have occurred on the date stated above, at 6:30 p.m.

Immediate cause of death	Duration
Broncho Pneumonia	2 wks
Due to	
Due to	
Other conditions Diabetes Mellitis (Include pregnancy within 3 months of death)	3 yrs

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) T. J. Carnecelli, M. D.
(Address) 154 Union Ave., Framingham Date 3/12, 1943

21 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Everett (Cemetery) (City or Town)
DATE OF BURIAL March 14, 1943

22 NAME OF FUNERAL DIRECTOR Robert M.F.Brown & Sons
ADDRESS 36 Trapelo Rd., Belmont, Mass

Received and filed May 19-1943
(Registrar of City or Town where deceased resided)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD
CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH: Worcester (County) Southbora (City or Town) No. Lyman St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ellen {O'Connell} Salmon (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR)

(a) Residence. No. Lyman St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Patrick M Salmon (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive 75 years

7 IF STILLBORN, enter that fact here.

8 AGE 70 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation:

10 Industry or Business: at Home

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

13 NAME OF FATHER David O'Connell

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Hannah Toomey

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant P. M. Salmon (Address) Lyman St Southbo Relation, if any (Husband)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Feeley (Signature of Agent of Board of Health or other)

Agent (Official Designation) March 15, 1943. (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 13 1943 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1942, to March 13, 1943

I last saw h.. alive on March 13, 1943, death is said to have occurred on the date stated above, at 5.15 P. M.

Immediate cause of death — Duration

(a) Mitral Regurgitation — several years

Due to

(b) Congestive Heart Failure — 3 weeks

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none

Date of

Of autopsy none

What test confirmed diagnosis? Clinical Sig

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No Yes

If so, specify

(Signed) F. Shelley, M. D.

(Address) 129 Main St Marlboro Date 3/15 1943

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 16 1943

22 NAME OF FUNERAL DIRECTOR Wm M Tighe

ADDRESS Marlboro Mass

Received and filed 19

A TRUE COPY ATTEST: (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-'39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No.

1 PLACE OF DEATH: WORCESTER (County); WORCESTER (City or Town); No. St Vincent Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John J Doherty (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) no

(a) Residence. No. Highland Rd St. Southboro (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution yes Hospital (Specify whether) years months 31 days. In this community yrs. mos. 31 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 59 Years 3 Months 25 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Carpenter

10 Industry or Business: Own business & contract

11 Social Security No. 022-01-2705

12 BIRTHPLACE (City) Boston (State or country)

PARENTS

13 NAME OF FATHER John J

14 BIRTHPLACE OF FATHER (City) Boston (State or country)

15 MAIDEN NAME OF MOTHER Margaret M Power

16 BIRTHPLACE OF MOTHER (City) Boston (State or country)

17 Informant Mrs. Mary Mooney (Relation, if any) Sister
(Address) Southboro

A TRUE COPY.
ATTEST: Malcolm C. McLean
(Registrar of city or town where death occurred)
DATE FILED March 26, 1943 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 23, 1943 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 19 43 to March 23, 19 43

I last saw him alive on March 23, 19 43, death is said to have occurred on the date stated above, at 2:50 p.m.

Immediate cause of death	Duration
Uremia	2 days
Due to Pyelonephritis	1½ mos
" " Retroperitoneal abscess	1½ mos
Due to Septic knee joint	2 "

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Date of
Of autopsy Above- portal cirrhosis
What test confirmed diagnosis? hepatoma

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) John J Rearick, M. D.
(Address) Worcester Date 3-23 19 43

21 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, Malden (Cemetery) (City or Town)
DATE OF BURIAL March 26, 1943 19

22 NAME OF FUNERAL DIRECTOR MaCrea & Sons Inc. by Edwin A. MacCrea
ADDRESS Worcester

Received and filed 19
(Registrar of City or Town where deceased resided)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to Insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m (d)-1-41-4067

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Baker's Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME John J. Hogan (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Pleasant St. Marlborough (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution Rest Home years 9 months days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of Margaret W. Lynch (Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 70 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: .....

10 Industry or Business: Cattle Dealer

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Marlboro Mass.

PARENTS

13 NAME OF FATHER: Patrick Hogan

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Mary Brewin

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address) Mrs Anna Bordelesse (Relation, if any: Niece) 97 Warren Ave. Marlboro.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agent April 15, 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: April (Month) 13 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan, 1942, to April 13, 1943

I last saw h. alive on April 13, 1943, death is said to have occurred on the date stated above, at 11 p.m.

Immediate cause of death: Cerebral hemorrhage — Duration IMPORTANT: One wk.

Due to: Diffuse arterial sclerosis — 2 yrs.

Due to: with hypertension

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: None — Date of .....

Of autopsy ..... What test confirmed diagnosis? Physical signs

IMPORTANT

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) John F. Collins, M. D.

(Address) Marlboro Mass. Date April 14 1943

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal (Cemetery) (City or Town)

DATE OF BURIAL April 16, 1943

22 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS Marlboro. Mass.

Received and filed ..... 19 .....

(Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 9

1 PLACE OF DEATH: Worcester (County) / Southboro (City or Town) / No. Melendy Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frederick Brown Gleason
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Ward St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 2 yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of Katherine Townsend
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 90 Years 7 Months 0 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired machinist

10 Industry or Business: .....

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Marlboro Mass.

PARENTS

13 NAME OF FATHER: Sidney B. Gleason

14 BIRTHPLACE OF FATHER (City) Sudbury (State or country) Mass.

15 MAIDEN NAME OF MOTHER: Eliza Jane Wheeler

16 BIRTHPLACE OF MOTHER (City) (State or country) New Hampshire

17 Informant: Sidney Gleason (Relation, if any: Brother)
(Address) Wollaston, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) May 1, 1943 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: May (Month) 1 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from March 25, 1943, to April 30, 1943

I last saw him alive on April 30, 1943 death is said to have occurred on the date stated above, at 9 A.M.

	Duration
Immediate cause of death: Bronchopneumonia	6 days
Due to: Influenza	6 days
Due to:	
Other conditions: Arteriosclerosis (Include pregnancy within 3 months of death)	-3-

IMPORTANT

Major findings: Of operations: none Date of .....
Of autopsy: none
What test confirmed diagnosis? Clinical Course

IMPORTANT
Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Harold A. Washburn, M. D.
(Address) Marlboro Date May 1 1943

21 Mathewson & Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 4, 1943

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15 Collins Ave., Marlboro, Mass.

Received and filed ..... 19.....
(Registrar)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. _____

State of Maine

1. PLACE OF DEATH:
(a) County Cumberland
(b) City or town Brunswick (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: _____ (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County Worcester
(c) City or town Southboro (If outside city or town limits, write RURAL)
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) FULL NAME Henry H. Stevens

3. (b) If veteran, name war No. 2 World
3. (c) Social Security No. _____

4. Sex M | 5. Color or race W | 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Esther Winnifred
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 27, 1898 (Month) (Day) (Year)

8. AGE: Years 44 | Months 9 | Days 20 | If less than one day _____ hr. _____ min.

9. Birthplace Maine (City, town, or county) (State or foreign country)
10. Usual occupation Machinist
11. Industry or business U. S. Coast Guard

MOTHER
12. Name Maine
13. Birthplace Maine (City, town, or county) (State or foreign country)
FATHER
14. Maiden name Maine
15. Birthplace Maine (City, town, or county) (State or foreign country)

16. (a) Informant's own signature John M. Dunn
(b) Address _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 19, 1943 (Month) (Day) (Year)
(c) Place; burial or cremation Framingham, Mass.

18. (a) Signature of funeral director Hayes Peabody
(b) Address Portland, Maine

19. (a) May 19, 1943 (Date received local registrar) (b) John W. Riley (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month May day 17
year 1943 hour _____ minute _____

21. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__:
that I last saw h__ alive on _____, 19__:
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Strangulation,	
Due to dislocation of 3rd.	
Cervical vertebra and	
Due to fractures of thyroid	
Abstilage & trachea.	
Other conditions Automobile accident	

(Include pregnancy within 3 months of death)

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident.
(b) Date of occurrence _____
(c) Where did injury occur? Brunswick, Cumb. Co. Me. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Public (Specify type of place)
While at work? _____ (e) Means of injury Auto acc.

23. Signature Harvey Howard (M. D. or other) ded.
Address Freeport, Me. Date signed 6 June.

8-6917 U. S. GOVERNMENT PRINTING OFFICE 13—13493

rm H—Death

COPY OF THE RECORD OF A DEATH

turned to the clerk of Southboro, Mass.
as is provided in Section 70 of Chapter 1, Public Laws of 1933.

ll name Henry G. Stevens

ace of death Brunswick, Maine
(If outside city or town limits, write RURAL)

me of hospital or institution
not in hospital or institution write street No. or location)

ngth of stay: In hospital or institution

In this community

ual residence of deceased: State Mass.

County Middlesex

y or Town Southboro

reet No.

veteran, name war U. S. Coast Guard World War No. 2

cial Security No.

x male Color White Married, Single, Widowed or Divorced married

me of husband or wife Esther Winnifred

ge of husband or wife, if alive yes

rth date of deceased: Year 45 Month 9 Day 20

e: Years 45 Months 9 Days 20 If less than one day hr. minutes

rthplace
(City, town or county) (State or foreign country)

sual occupation Motor Machinist

dustry or business U. S. Coast Guard

ther: Name Unknown

Occupation

Birthplace
(City, town or county) (State or foreign country)

other: Maiden name Unknown

Birthplace
(City, town or county) (State or foreign country)

ame of informant John M. Dunn

ate of death: Month May Day 17 Year 1943

mediate cause of death Strangulation due to dislocation of 3rd cervical vertebrae and fracture of thyroid cartilege and trachea Duration

ue to

ther conditions automobile accident

Major findings: Of operations .....

Of autopsy .....

If death was due to external causes, fill in the following:

Accident, suicide, or homicide (specify) .....

Date of occurrence .....

Where did injury occur? .....

Did injury occur in or about home, on farm, in industrial place, in public place? .....

While at work? ..... Means of injury .....

Name of physician Harvey Howard, Med.

P. O. Address Freeport, Maine

Place of burial Framingham, Mass.

Date of burial May 19, 1943

Name of Cemetery .....

Funeral Director (Embalmer) Hay & Peabody

P. O. Address 749 Congress St., Portland

Date when received by Town Clerk May 19, 1943

State of Maine

I hereby certify that the above is a true copy of the Record of a Death made by the clerk of Brunswick in the month of June 19 43

Madeleine M. Mason

Deputy Clerk of Brunswick, Maine

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 15

1 PLACE OF DEATH: Worcester (County) — Southborough (City or Town) — No. Lodi grove Rd (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Emeline Blanchard (Mrs Blood) (If deceased is a married, widowed or divorced woman, give also maiden name.) — (If U. S. War Veteran, specify WAR)

(a) Residence. No. Wood St (Usual place of abode) St Hopkinton, Mass. (If nonresident, give city or town and state)

Length of stay: In hospital or institution Rest Home (Specify whether) years 8 months days. In this community 19 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female — 4 COLOR OR RACE: white — 5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of John Blanchard
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 97 Years 11 Months Days — If less than 1 day Hours Minutes

9 Usual Occupation: housewife retired

10 Industry or Business: Own home

11 Social Security No. xxx

12 BIRTHPLACE (City) (State or country) Grafton Mass

PARENTS

13 NAME OF FATHER: Timothy Aldrich

14 BIRTHPLACE OF FATHER (City) (State or country) Grafton Mass

15 MAIDEN NAME OF MOTHER: Elizabeth Cartwright

16 BIRTHPLACE OF MOTHER (City) (State or country) Grafton Mass

17 Informant (Address) Records Town Hall Relation, if any (guardian)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Telfer
(Signature of Agent of Board of Health or other)

Agent. (Official Designation) May 19, 1943 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: May (Month) 19 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 15, 1943, to May 19, 1943

I last saw h.e. alive on May 15, 1943, death is said to have occurred on the date stated above, at 5:30 A.M.

	Duration
Immediate cause of death: Coronary occlusion	10 hours
Due to Arteriosclerosis	3 -
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: none
Date of
Of autopsy
What test confirmed diagnosis?

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If no, specify
(Signed) Roland C Washburn M. D.
(Address) Central Worcester Date May 19, 1943

21 Bellevue Cemetery Lawrence Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 22 1943

22 NAME OF FUNERAL DIRECTOR Vernon E. Morrill
ADDRESS 15 Church St Hopkinton Mass.

Received and filed May 25 1943 1943

A TRUE COPY ATTEST: (Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 1 1

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southborough; No. Cook Hill Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nathan Fradsicks Woodworth (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Cook Hill Rd St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Specify whether) In this community 48 yrs. ..... mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 1 Months 17 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: grocer - retired

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Hopkinton Mass

PARENTS

13 NAME OF FATHER Joseph S Woodworth

14 BIRTHPLACE OF FATHER (City) (State or country) Hopkinton Mass

15 MAIDEN NAME OF MOTHER Mary M. Woodson

16 BIRTHPLACE OF MOTHER (City) (State or country) Hopkinton Mass

17 Informant (Address) Mildred W. Woodworth Framingham (Relation, if any) daughter

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Telfer
(Signature of Agent of Board of Health or other)

Agent. May 22 1943.
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May (Month) 20 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 6, 1931, to May 20, 1943, I last saw h[illegible] alive on May 20, 1943, death is said to have occurred on the date stated above, at 2.40 P. m.

	Duration
Immediate cause of death: Myocardial Insufficiency	10 yrs.
Due to Arterio sclerosis	-2-
Due to	
Other conditions (Include pregnancy within 3 months of death) Hypertrophy prostate	

Major findings:
Of operations none
Date of .....
Of autopsy none
What test confirmed diagnosis? Physical examination

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) Edward F Bradford, M. D.
(Address) Hopkinton Mass Date May 21 1943

21 Mt Auburn Cemetery Superintendent's Office
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL May 22 1943

22 NAME OF FUNERAL DIRECTOR Frederick A Cook Son
ADDRESS 318 Union Ave Framingham Mass

Received and filed May 25 1943 (Registrar)

A TRUE COPY ATTEST: E E Fairbanks

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK – THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

BOSTON (City or town making return)

Registered No. 5622

1 PLACE OF DEATH: (SUFFOLK (County) / BOSTON (City or Town)

No. The Children's Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Randall Gordon (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Northboro Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution hospital (Before death) (Specify whether) years months 16 days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE Years 1 Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: none

10 Industry or Business: ----

11 Social Security No. ----

12 BIRTHPLACE (City) (State or country): Milton, Vermont

PARENTS

13 NAME OF FATHER: Harry Gordon

14 BIRTHPLACE OF FATHER (City) (State or country): Milton, Vermont

15 MAIDEN NAME OF MOTHER: Laurette Pidgeon

16 BIRTHPLACE OF MOTHER (City) (State or country): Grand Isle, Vermont

17 Informant (Address) (Relation, if any): Father

A TRUE COPY. ATTEST: Francis J. Gay (Registrar of city or town where death occurred)

DATE FILED June 9 1943

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: June (Month) 6 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 21, 1943, to June 6, 1943

I last saw him alive on June 6, 1943, death is said to have occurred on the date stated above, at 11.40 p.m.

Immediate cause of death: Respiratory Failure — Duration: 1 day

Due to: Acute Nutritional Disturbance

Interstitial Pneumonia

Due to: Diarrhea

Other conditions: Harelip, post op. (Include pregnancy within 3 months of death)

Major findings: Of operations ..... Date of .....

Of autopsy .....

What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) F. C. Chisholm, M. D.

(Address) Boston Date 6-7 1943

21 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Anne's Cem. (Cemetery) Milton, Vt. (City or Town)

DATE OF BURIAL June 10 1943

22 NAME OF FUNERAL DIRECTOR: A. L. Eastman Co., Inc.

ADDRESS: Boston, Mass.

Received and filed June 11 1943

(Registrar of City or Town where deceased resided)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-10-39. No. 8427-i

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Turnpike Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William E Wentworth (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Turnpike Rd St. ..... (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution ..... years months days. In this community 20 yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Gladys Miller
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive 44 years

7 IF STILLBORN, enter that fact here.

8 AGE 59 Years 1 Months 29 Days | If less than 1 day Hours ..... Minutes

9 Usual Occupation: Victualler & gas station proprietor

10 Industry or Business: Owner.

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Webster Mass.

PARENTS

13 NAME OF FATHER Adolph Wentworth

14 BIRTHPLACE OF FATHER (City) (State or country) England

15 MAIDEN NAME OF MOTHER Mary Goodnow

16 BIRTHPLACE OF MOTHER (City) (State or country) Canada

17 Informant Gladys Wentworth (Wife) (Address) Turnpike Southboro
Relation, if any

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agent. July 15, 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: July (Month) 13 (Day) 1943 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Chronic cardiac
Bronchial Asthma

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19 .....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, in public place? .....
(Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? — Was there an autopsy? —

21 Was disease or injury in any way related to occupation of deceased? —

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date July 13 1943

22 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL July 15, 1943

23 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS Marlboro, Mass.

Received and filed July 24 1943

Edward L. Fairbanks
(Registrar)

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK OR USE APPROVED BLACK TYPEWRITER RIBBON — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25M-4-59-925100

The Commonwealth of Massachusetts
JOSEPH D. WARD
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. n 158

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town)

No. Jenney Gas Station E.Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME MICHAEL ALBERINI (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Marlboro rd St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 22, 1943 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

heart disease, presumably
coronary sclerosis

5 Accident, suicide, or homicide (specify) no

Date and hour of injury .....19.....

If accidental, was injury causally related to the death? .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? no (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) William D.Roche, M. D.

(Address) Marlborough Date 7/22 19 43

7 St.John,Hopkinton Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL July 24 19 43

8 NAME OF FUNERAL DIRECTOR Wm.M.Tighe

ADDRESS Marlborough

Received and filed June 22 19 62

Eleanor F Burke (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: m

10 COLOR: w

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

11a If married, widowed, or divorced HUSBAND of Regina Farina (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 59 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

14 Usual Occupation: meat cutter (Kind of work done during most of working life)

15 Industry or Business: Deerfoot farm

16 Social Security No. 024-03--3420

17 BIRTHPLACE (City) Iraly (State or country)

PARENTS

18 NAME OF FATHER Louis Alberini

19 BIRTHPLACE OF FATHER (City) (State or country) Italy

20 MAIDEN NAME OF MOTHER Domenico Prini

21 BIRTHPLACE OF MOTHER (City) (State or country) Italy

22 Informant Julia Pazarisky daughter (Address) 158 Howe St., Marlborough

A TRUE COPY.

ATTEST: Alice I. Lapierre (Registrar of City or Town where death occurred)

DATE FILED July 24 19 43

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town) No. Marlboro Rd Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD
CERTIFICATE OF DEATH

(City or town making return)

Registered No.

2 FULL NAME Andrew W Fitzgerald (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR) none

(a) Residence. No. Marlboro Rd Southboro St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Julia O'Connell (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 78 years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years 11 Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired Merchant

10 Industry or Business: meat

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

13 NAME OF FATHER John R Fitzgerald

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Julia Sweeney

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Julia Fitzgerald Southboro Mass Relation, if any Daughter

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)
Burial Agent July 23, 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 23 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 22, 1943, to July 23, 1943

I last saw h.. alive on July 22, 1943, death is said to have occurred on the date stated above, at 7.20 a.m.

	Duration
Immediate cause of death: Chronic Nephritis	
Due to Chronic myocarditis	6 mo.
Due to arteriosclerosis	years
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none Date of
Of autopsy no
What test confirmed diagnosis?

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) C W Smith, M. D.
(Address) Marlboro Date 7/23, 1943

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL July 26 1943

22 NAME OF FUNERAL DIRECTOR W F M Tighe
ADDRESS Marlboro Mass

Received and filed July 24 1943
A TRUE COPY ATTEST: Chandler L. Fairbanks (Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town) No. Latisquama Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME. Frank (White) Leblene. (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran specify WAR)

(a) Residence. No. 484 Lincoln St St. Marlboro (If nonresident, give city or town and state)
(Usual place of abode)
Length of stay: In hospital or institution. Rest Home (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Lea Bourgeois
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years Months 10 Days | If less than 1 day Hours Minutes

9 Usual Occupation: None Retired Shoemaker

10 Industry or Business:

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Southboro Mass

PARENTS

13 NAME OF FATHER Peter White

14 BIRTHPLACE OF FATHER (City) (State or country) Worcester Mass

15 MAIDEN NAME OF MOTHER Rose Harpin

16 BIRTHPLACE OF MOTHER (City) (State or country) Worcester Mass

17 Informant Jane White (Address) 484 Lincoln Relation, if any (Daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Teeter
(Signature of Agent of Board of Health or other)
Burial Agent August 24. 1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Aug (Month) 24 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1943, to Aug 24, 1943
I last saw him alive on Aug 22, 1943, death is said to have occurred on the date stated above, at 6.00 a.m.

	Duration
Immediate cause of death	
Arteriosclerosis Cerebrosis	3
Due to	
Due to	
Other conditions Arteriosclerosis (Include pregnancy within 3 months of death)	3

PHYSICIAN

Underline the cause to which death should be charged statistically.

Major findings:
Of operations none
Date of
Of autopsy none
What test confirmed diagnosis? Physical exam

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Roland J Wheeler, M. D.
(Address) Marlboro Mass Date 8/24 1943

21 St Marys Cemetery Marlboro Mass.
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL August 26 1943

22 NAME OF FUNERAL DIRECTOR Henry F. Harpin
ADDRESS 93 Burnap St Marlboro

Received and filed 19

A TRUE COPY ATTEST: (Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 17

1 PLACE OF DEATH: Worcester (County) Southborough (City or Town)
No. Ladies Grove Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John C Stone (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Main St. Hopkinton, Mass (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution Rest Home (Specify whether) years months days. In this community 90 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 91 Years - Months 10 Days | If less than 1 day Hours ..... Minutes

9 Usual Occupation: Shoe Cutter
10 Industry or Business: Shoe Mfg. Co.
11 Social Security No. None
12 BIRTHPLACE (City) (State or country) Roxbury Mass.

PARENTS

13 NAME OF FATHER: John C. Stone
14 BIRTHPLACE OF FATHER (City) (State or country): White Church Ireland
15 MAIDEN NAME OF MOTHER: Mary Kenington
16 BIRTHPLACE OF MOTHER (City) (State or country): White Church Ireland

17 Informant (Address): Helen E. Phipps 1 Gloucester St. Boston, Mass. Relation, if any: Niece

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tefft (Signature of Agent of Board of Health or other)
Burial Agent (Official Designation) Sept 1 - 1943 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: August (Month) 30 (Day) 1943 (Year)

19 I HEREBY CERTIFY. That I attended deceased from July 5, 1943, to Aug 30, 1943
I last saw h. alive on Aug 28, 1943, death is said to have occurred on the date stated above, at 10.45 P.M.

	Duration
Immediate cause of death: Myocardial Insufficiency	-1-
Due to Arterio sclerosis	-3-
Due to	
Other conditions (Include pregnancy within 3 months of death): senile	

Major findings:
Of operations: none
Date of
Of autopsy: none
What test confirmed diagnosis? Physical Examination

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Roland J Newton, M. D.
(Address) 6 Main Street Hopkinton Date Aug 31 1943

21 Mt. Auburn Hopkinton Mass.
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL Sept 2, 1943

22 NAME OF FUNERAL DIRECTOR: Vernon E. Morrill
ADDRESS 15 Church St. Hopkinton, Mass.

Received and filed ..... 19....

A TRUE COPY ATTEST: (Registrar)

FORM R-301 A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. 1 Fay Court St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clara A. (Benson) Babbitt
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 1 Fay Court St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution — years — months — days. (Before death) (Specify whether) In this community 30 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Albert F. Babbitt
(Husband's name in full)

6 Age of husband or wife if alive 67 years

7 IF STILLBORN, enter that fact here.

8 AGE 68 Years 9 Months 11 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: own home

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Somerset Mass

PARENTS

13 NAME OF FATHER Lothrop W. Benson

14 BIRTHPLACE OF FATHER (City) (State or country) East Windham Mass

15 MAIDEN NAME OF MOTHER Sarah Sherman

16 BIRTHPLACE OF MOTHER (City) (State or country) East Windham Mass

17 Informant (Address) 1 Fay Court Southboro Mass. Relation, if any husband

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Sefton
(Signature of Agent of Board of Health or other)

Agent. Sept 28. 43.
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH September 26 1943
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1943, to Sept 26, 1943

I last saw h.. alive on Sept 26, 1943, death is said to have occurred on the date stated above, at 11 P m.

Duration

Immediate cause of death
IMPORTANT
Apoplexy Cerebral — 6 days

Due to Arterio sclerosis chronic — 7 —

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations none — Date of .....
Of autopsy none
What test confirmed diagnosis? .....

IMPORTANT
Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Malcolm C. Macfarlane, M. D.
(Address) Marlboro Mass. Date Sept 28 1943

21 Burial Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Sept 29 1943

22 NAME OF FUNERAL DIRECTOR Irving W. Harper
ADDRESS 62 West Main St Northboro Mass

Received and filed ..... 19.....
(Registrar)

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m (d)-1-41-4667

FORM R-301 A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. ....

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. Boston Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James William Robbins
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) ....

(a) Residence. No. Boston Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) .... years .... months .... days. In this community 27 yrs. .... mos. .... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of: Marion E. Howes (Give maiden name of wife in full)
(or) WIFE of: .... (Husband's name in full)

6 Age of husband or wife if alive: 52 years

7 IF STILLBORN, enter that fact here. ....

8 AGE 59 Years 9 Months 6 Days | If less than 1 day .... Hours .... Minutes

9 Usual Occupation: Hydro-electrical engineer

10 Industry or Business: Metropolitan Water Com.

11 Social Security No. ....

12 BIRTHPLACE (City) (State or country): Lynnfield(?) Mass.

PARENTS

13 NAME OF FATHER: John Robbins

14 BIRTHPLACE OF FATHER (City) (State or country): —— Massachusetts

15 MAIDEN NAME OF MOTHER: Anna Ramsdell

16 BIRTHPLACE OF MOTHER (City) (State or country): Massachusetts

17 Informant: Marion E. Robbins (Relation, if any: Wife)
(Address): Boston Road

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
James F. Telfer
(Signature of Agent of Board of Health or other)
Agent (Official Designation) — Sept. 29-43 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: September (Month) 28 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1941, to Sept 28, 1943,
I last saw him alive on Sept 27, 1943, death is said to have occurred on the date stated above, at 5 A m.

Duration

Immediate cause of death: Paraplegia spastic hereditary(?) — IMPORTANT

Due to ....

Due to ....

Other conditions (Include pregnancy within 3 months of death) .... IMPORTANT

Major findings:
Of operations: none
.... Date of ....
Of autopsy: none
What test confirmed diagnosis? Physical exam(?) clinical(?) ....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify ....
(Signed) [illegible] M. D.
(Address) [illegible] Date Sept 29, 1943

21 Rural(?) — Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL September 30, 1943

22 NAME OF FUNERAL DIRECTOR: Sumner C. Gage
ADDRESS: Marlboro, Mass.

Received and filed .... 19.... [illegible] (Registrar)

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

FORM R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. chap. 46, section 10, requires physicians to insert a recital to that effect.

50m (f)-1-41-4667

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Deerfoot Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elgen J. Rowe
(If deceased is a married, widowed or divorced woman, give also maiden name.)

Physician — Important (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Deerfoot Rd. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 31 yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Jennie R. Coons
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive 68 years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years 0 Months 23 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Indoor advertising

10 Industry or Business: Food display at expositions

11 Social Security No. None.

12 BIRTHPLACE (City) (State or country) Windsor Ontario

PARENTS

13 NAME OF FATHER ——— Rowe

14 BIRTHPLACE OF FATHER (City) (State or country) Unknown Canada

15 MAIDEN NAME OF MOTHER Jennie Whitney

16 BIRTHPLACE OF MOTHER (City) (State or country) Unknown Canada

17 Informant (Address) Jennie R. Rowe Deerfoot Road (Relation if any) Wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tefft
(Signature of Agent of Board of Health or other)

Burial Agent. Oct 11-1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Oct 9 1943
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death Presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19.....

Where did Injury occur? .....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? ..... Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter Hughson, M. D.

(Address) Westborough Date Oct 9 1943

22 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL October 12, 1943

23 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS Marlboro, Mass.

Received and filed October 26 1943

A TRUE COPY ATTEST: ..... (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 178

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Loren Kelley (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) no

(a) Residence. No. Central St. Fayville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Institution 5 years 8 months 23 days. (Before death) (Specify whether) In this community 59 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of Anna Brill (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 11 Months 4 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Laborer & Farmer

10 Industry or Business: For town & Farming

11 Social Security No.

12 BIRTHPLACE (City) New York (State or country) N. Y.

PARENTS

13 NAME OF FATHER John Kelley

14 BIRTHPLACE OF FATHER (City) Albert (State or country) Vt.

15 MAIDEN NAME OF MOTHER Adelia Spencer

16 BIRTHPLACE OF MOTHER (City) Fort Covington (State or country) N. Y.

17 Informant (Address) Westborough State Hospital records (Relation, if any)

A TRUE COPY. Anne A. Dunne

ATTEST: (Registrar of city or town where death occurred)

DATE FILED October 14, 1943

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH October (Month) 12th, (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1941, to Oct. 12, 1943

I last saw him alive on Oct. 12, 1943, death is said to have occurred on the date stated above, at 11:15 a.m.

	Duration
Immediate cause of death: Chronic myocarditis	unk.
Due to: Generalized arteriosclerosis	unk.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ..... Date of .....

Of autopsy not done

What test confirmed diagnosis? Clin & Lab.

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) James G. Boyd, M. D.

(Address) Westborough, Mass Date 10/12 1943

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural (Cemetery) Southboro, Mass (City or Town)

DATE OF BURIAL October 14, 1943

22 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS Marlboro, Mass.

Received and filed November 12, 1943

(Registrar of City or Town where deceased resided)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-2-'40-D-729-b

1 PLACE OF DEATH: Worcester (County) / Southborough (City or Town)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No.....

No. Latisquama Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number) Baker Rest Home

2 FULL NAME John Douglas (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR).....

(a) Residence. No. 12 Allen St. Northborough Mass (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... (Specify whether) years months days. In this community yrs. mos. 21 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

6 Age of husband or wife if alive.....years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years 10 Months 13 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Mill Hand (Retired)

10 Industry or Business:

11 Social Security No.....

12 BIRTHPLACE (City) (State or country) Dublin Ireland

PARENTS

13 NAME OF FATHER: Samuel Douglas

14 BIRTHPLACE OF FATHER (City) (State or country): Cannot be learned England

15 MAIDEN NAME OF MOTHER: Mary Mulligan

16 BIRTHPLACE OF MOTHER (City) (State or country): Cannot be learned Ireland

17 Informant: Old Age Assistance (Relation, if any) (Address) Florence Swenson Agt. Hopkinton Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Francis F. Fuller (Signature of Agent of Board of Health or other)

Burial Agent. Oct 14, 1943 (Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Oct (Month) 13 (Day) 1943 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cerebral sclerosis terminal disease

20 Accident, suicide, or homicide (specify).....

Date of occurrence.....19.....

Where did Injury occur?..... (City or Town and State)

Did injury occur in or about home, on farm, in industrial place, in public place?

..... (Specify type of place)

Manner of Injury.....

Nature of Injury.....

While at work?.....Was there an autopsy?.....

21 Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Walter F. Mahoney, M. D.

(Address) Westboro Mass Date Oct 14 19 43

22 Howard St. Cemetery Northborough
Place of Burial, Cremation or Removal (City or Town)

DATE OF BURIAL Oct 16 19 43

23 NAME OF FUNERAL DIRECTOR S. Standish Stephenson

ADDRESS 19 Pleasant St. Northborough Mass

Received and filed October 26, 19 43

Thos. F. Fay Clerk

(Registrar)

FORM R-301 A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. ....

1 PLACE OF DEATH

Worcester (County)

Southboro (City or Town)

No. Oak Hill Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Annie E. (Quigley) McCloskey
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence. No. Oak Hill Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution none (Before death) (Specify whether) years months days. In this community 38 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED ✓ or DIVORCED (write the word): widow

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of John H McCloskey (deceased 1933) (Husband's name in full)

6 Age of husband or wife if alive: dead years

7 IF STILLBORN, enter that fact here.

8 AGE 71 Years 6 Months 23 Days. If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: at home

10 Industry or Business: none

11 Social Security No. none

12 BIRTHPLACE (City) (State or country): Framingham

PARENTS

13 NAME OF FATHER: Peter Quigley

14 BIRTHPLACE OF FATHER (City) (State or country): Donegal Ireland

15 MAIDEN NAME OF MOTHER: Bridget Kelley

16 BIRTHPLACE OF MOTHER (City) (State or country): Galway Ireland

17 Informant: Daniel W. L. Keefe (Address) 12 Grant St. Framingham Mass. Relation, if any (nephew)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Teefer (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Oct 24. 1943 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: October (Month) 22 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1938, to Oct 22, 1943

I last saw her alive on Oct 22, 1943, death is said to have occurred on the date stated above, at 11.55 P. m.

	Duration
Immediate cause of death: Heart disease - Coronary disease	3
Due to arterio sclerosis	3
Due to	
Other conditions (Include pregnancy within 3 months of death) abdominal neoplasm	3

IMPORTANT Physician: Underline the cause to which death should be charged statistically.

Major findings:
Of operations: none
Date of ....
Of autopsy: none
What test confirmed diagnosis? physical examination [illegible]

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Roland [illegible], M. D.
(Address) Westboro Mass Date Oct 23 1943

21 Burial Cemetery Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL October 25 1943

22 NAME OF FUNERAL DIRECTOR John A Cunningham
ADDRESS Framingham

Received and filed October 27, 1943

(Registrar)

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Baker Rest Home St. Latisquama rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Colasta (Ricci) Phillipo (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Learned St. ..... (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months 6 days. (Before death) (Specify whether) In this community 40 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: femal | 4 COLOR OR RACE: white | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of John Phillipo (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 62 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: At Home

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country): Italy

PARENTS

13 NAME OF FATHER: Millio Ricci

14 BIRTHPLACE OF FATHER (City) (State or country): Italy

15 MAIDEN NAME OF MOTHER: Berdelnia Ricci

16 BIRTHPLACE OF MOTHER (City) (State or country): Italy

17 Informant Elmer J. Phillipo (Address) Box 84 Southboro Mass Relation, if any Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Sieber
(Signature of Agent of Board of Health or other)

Burial Agent Nov 9-1943
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Nov (Month) 8 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug, 1943, to Nov, 1943

I last saw he alive on Nov 7, 1943, death is said to have occurred on the date stated above, at 12.30 A m.

	Duration
Immediate cause of death: Cerebral Hemorrhage	IMPORTANT 4 days
Due to: Gen arteri Sclerosis	unknown
Due to:	
Other conditions (Include pregnancy within 3 months of death)	IMPORTANT

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? Skeletocopy

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Walter F Mahoney, M. D.
(Address) Westboro Date Nov 8 1943

21 Rural cemetery, Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL November 10, 1943

22 NAME OF FUNERAL DIRECTOR William M. Tighe
ADDRESS Windsor St Marlboro Mass

Received and filed November 10, 1943
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH
(City or town making return)

Registered No. .....

1 PLACE OF DEATH

MIDDLESEX (County)

MARLBOROUGH (City or Town)

No. Marl Hosp St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Inft Mabie (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Boston Turnpike Rd St. Fayville Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution..... years months days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word) single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here. stillborn

8 AGE .....Years.....Months.....Days | If less than 1 day .....Hours.....Minutes

9 Usual Occupation: .....

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Marlborough Mass

PARENTS

13 NAME OF FATHER William Mabie

14 BIRTHPLACE OF FATHER (City) Framingham (State or country) Mass

15 MAIDEN NAME OF MOTHER Ruth M. Wiles

16 BIRTHPLACE OF MOTHER (City) Framingham (State or country) Mass

17 Informant Lillian M. Wiles grmother
(Address) Leonard Ct. Southboro Mass

A TRUE COPY.
ATTEST: F. J. Bertrand
(Registrar of city or town where death occurred)

DATE FILED Dec 9 1943 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec 2 1943
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....
I last saw h.....alive on....., 19....., death is said to have occurred on the date stated above, at.....m.

Duration

Immediate cause of death
premature
stillborn 5½ months
Due to also hydro ceph mons

Due to .....

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
Date of.....
Of autopsy.....
What test confirmed diagnosis?.....

Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) Albert E. LeMarbre M. D.
(Address) Marlborough Dec 2 1943 Date 19

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Southboro
(Cemetery) (City or Town)
DATE OF BURIAL Dec. 4 1943 19

22 NAME OF FUNERAL DIRECTOR Sumner E. Cage
ADDRESS Marlborough Mass

Received and filed..... 19.....
(Registrar of City or Town where deceased resided)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) East Brookfield; No. Winchester St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Oscar Mirsman (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Winchester St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution —0— years months days. (Specify whether) In this community 53 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of Margaret L. Reynolds (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 77 years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years 4 Months 9 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Foreman of Foundry

10 Industry or Business: Private Foundry Shop

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) East Brookfield Nova Scotia

PARENTS

13 NAME OF FATHER James Mirsman

14 BIRTHPLACE OF FATHER (City) unascertainable (State or country) Nova Scotia

15 MAIDEN NAME OF MOTHER Ann Roberts

16 BIRTHPLACE OF MOTHER (City) unascertainable (State or country) Nova Scotia

17 Informant (Address) Mrs. Margaret L. Mirsman East Brookfield Mass. Relation, if any (widow)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Dec 9 1943 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December 7 1943 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 1, 1935, to Dec 7, 1943

I last saw him alive on Dec 6, 1943, death is said to have occurred on the date stated above, at 6 A.M.

	Duration
Immediate cause of death: Coronary occlusion	6 minutes
Due to Arteriosclerosis	5 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Date of
Of autopsy none
What test confirmed diagnosis? Physical exam

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Ralph L. Wentworth, M. D.

(Address) 9 Central Worcester Mass Date Dec 7 1943

21 Rural Southboro
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL December 10 1943

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS Marlboro, Mass.

Received and filed Dec 27 1943

A TRUE COPY ATTEST: Charles L. Fairbanks (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 219

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town); No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Firmin, George A. P. (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Main St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) 8 years (Specify whether) 2 months 8 days. In this community 36 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 36 Years 3 Months 0 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Never able to work

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Framingham Mass.

PARENTS

13 NAME OF FATHER: George T. Firmin

14 BIRTHPLACE OF FATHER (City) Reading (State or country) England

15 MAIDEN NAME OF MOTHER: Catherine Pilkington

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Westborough State Hospital records (Relation, if any)

A TRUE COPY. ATTEST: Annie A. Dunn
(Registrar of city or town where death occurred)

DATE FILED Dec. 13, 1943

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December 10, 1943 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1941 to Dec. 10, 1943

I last saw him alive on Dec. 10, 1943, death is said to have occurred on the date stated above, at 3:00 p. m.

Immediate cause of death: Bronchopneumonia — Duration: Term.

DUE to: Pulmonary tuberculosis (active bilateral) — unk.

Due to: — 15-20 yrs

Other conditions: Paralysis Agitans
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Date of
Of autopsy: not done
What test confirmed diagnosis? Clinical, Lab. & X-ray

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) James G. Boyd, M. D.
(Address) Westboro, Mass. Date 12/10 1943

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Rural (Cemetery) Southboro, Mass (City or Town)
DATE OF BURIAL Dec. 13 1943

22 NAME OF FUNERAL DIRECTOR: Wm. M. Tighe
ADDRESS 3 Windsor St. Marlboro, Mass

Received and filed Jan. 10 1944
(Registrar of City or Town where deceased resided)

ORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-E-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southbridge (City or Town) — No. School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Louis C Bertonazzi (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence. No. School St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 38 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Louise Castignetti (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 51 years

7 IF STILLBORN, enter that fact here.

8 AGE 59 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Farmer

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Italy

PARENTS

13 NAME OF FATHER Peter Bertonazzi

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER Can not be Learned

16 BIRTHPLACE OF MOTHER (City) (State or country) Italy

17 Informant Louise Bertonazzi (Address) School St Southbridge (Relation, if any) Wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Telfer (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Jan. 2, 1944 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec (Month) 31 (Day) 1943 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept, 1942, to Dec 31, 1943

I last saw him alive on Dec 31, 1943 death is said to have occurred on the date stated above, at 5.30 P. m.

	Duration
Immediate cause of death — IMPORTANT: Congestive heart failure	3 weeks
Due to Arterio Sclerotic Heart Disease	1 year
Due to	
Other conditions (Include pregnancy within 3 months of death): Diabetes mellitus — IMPORTANT	5 yrs

Major findings: Of operations — Date of .....
Of autopsy —
What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Hugh F Folsom, M. D.
(Address) Fra Dunham Date Jan 1 1944

21 Burial Rural Southbridge Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Jan 4 1944

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed ..... 19.....
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate. If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physician to insert a recital to that effect.

100m(h)-1-41-4695

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. ✓

PLACE OF DEATH
1 (County) Worcester
(City or Town) Southboro
No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hannah G Bagley
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran? If so, specify WAR)

(a) Residence. No. East Main St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 74 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired Housekeeper

10 Industry or Business: Charles F. Choate

11 Social Security No. .....

12 BIRTHPLACE (City) Southboro (State or country) Mass

PARENTS

13 NAME OF FATHER Thomas H. Bagley

14 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

15 MAIDEN NAME OF MOTHER Hannah McDonough

16 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

17 Informant Minnie Johnson (Relation, if any Niece)
(Address) E. Main St Northboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tolfer
(Signature of Agent of Board of Health or other)

Burial Agent Jan. 2. 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan. 1 1944
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1943, to Dec 31, 1943
I last saw h-- alive on Dec 31, 1943, death is said to have occurred on the date stated above, at ..... m.

	Duration Important
Immediate cause of death: Coronary Thrombosis	5 days
Due to: Coronary Heart Disease	2 years
Due to: and Arteriosclerosis	
Other conditions: Chronic Myocarditis (Include pregnancy within 3 months of death)	Important

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Edgar F. Merrill, M. D.
(Address) Marlboro Mass Date Jan. 1 1944

21 Burial Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Jan 3, 1944

22 NAME OF FUNERAL DIRECTOR John D. Brogan
ADDRESS 70 W Main St Marlboro

Received and filed 1944

A TRUE COPY ATTEST: (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Upland Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Sarah Christina (Taylor) Carruthers (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Upland St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 29 yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Samuel Otis Carruthers
(Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 82 Years 2 Months 16 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At home

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country): Portland Maine

PARENTS

13 NAME OF FATHER: Alexander Taylor

14 BIRTHPLACE OF FATHER (City) (State or country): Prince Edward Island

15 MAIDEN NAME OF MOTHER: Mary F. Marden

16 BIRTHPLACE OF MOTHER (City) (State or country): Portsmouth New Hampshire

17 Informant (Address): Mrs Wm. F. Slade, Lowell, Mass. Relation, if any: (Daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Peters
(Signature of Agent of Board of Health or other)

Agent — Jan. 17 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Jan (Month) 17 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1 1919 19..... to Jan 17, 1944

I last saw h.er alive on Jan 16, 1944, death is said to have occurred on the date stated above, at ..... m.

Immediate cause of death ..... Duration
(a) Myocarditis chronic — 1930
Due to (b) Arteria Sclerosis chronic — 7

Due to .....

Other conditions ..... IMPORTANT
(include pregnancy within 3 months of death)

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? Physical exam

IMPORTANT
Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Edward C. Wentworth, M. D.
(Address) 9 Central Worthen Date Jan 17 1944

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL January 19 1944

22 NAME OF FUNERAL DIRECTOR Sumner C. Grace
ADDRESS 15 Cottage Ave., Marlboro

Received and filed Jan 21 1944
Chandler L. Fairbanks
(Registrar)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-11-'30. No. 605-a

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 1/

1 PLACE OF DEATH: (County) ..... (City or Town) Southboro No. 15 W. Main St. Rest Home St., ... Ward { (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alfred N. Pelletier (If deceased is a married, widowed or divorced woman, give also maiden name.) { (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. 15 Main St., Ward, Ashland Mass (If nonresident, give city or town and state)
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. days. How long in U. S., if of foreign birth? yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced
HUSBAND of Mary Slavyk (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 IF STILLBORN, enter that fact here.

7 AGE 70 Years 6 Months 2 Days | If less than 1 day ..... Hours ..... Minutes

OCCUPATION

8 Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Machinist

9 Industry or business in which work was done, as silk mill, saw mill, bank, etc. Lombard Governor

10 Date deceased last worked at this occupation (month and year) June, 1942

11 Total time (years) spent in this occupation 35 years

12 BIRTHPLACE (City) Chicopee Falls, Mass (State or country)

PARENTS

13 NAME OF FATHER Napolitan Joseph Pelletier

14 BIRTHPLACE OF FATHER (City) Canada (State or country)

15 MAIDEN NAME OF MOTHER Philomene Beltier

16 BIRTHPLACE OF MOTHER (City) Canada (State or country)

17 Informant Mrs. Mary Pelletier, Wife
(Address) 15 W. Main St., Ashland

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tekte
(Signature of Agent of Board of Health or other)

Burial Agent Jan. 19, 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan 17 1944 (Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully)

Cerebral hemorrhage

(See reverse side for description for unknown person)

20 If death was due to external causes (VIOLENCE) fill in the following:
Accident, Suicide or Homicide? Date of injury ..... 19.....
Where did injury occur? ..... (City or town and State)
Manner of Injury .....
Nature of Injury .....

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Walter Flaherty, M. D.
(Address) Westborough Date Jan 17 19 44

22 PLACE OF BURIAL, CREMATION OR REMOVAL Wildwood (Cemetery) Ashland (City or town)
DATE OF BURIAL Jan. 20 19 44

23 NAME OF UNDERTAKER (Mrs.) Ruth Hollander
ADDRESS 122 Hollis St., Framingham

Received and filed ..... 19.....
(Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100M-6-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Babcock Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Felix J Clancy (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 69 Howe St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 74 yrs. ..... mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 74 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Shoe Cutter (Retired)

10 Industry or Business: Shoe Factory

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

13 NAME OF FATHER: John Clancy

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: unk McGinnes

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address) Mrs Genie Curley 69 Howe St Marlboro Relation, if any (Sister)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Peters (Signature of Agent of Board of Health or other)

Burial Agent Jan. 1944 (Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: January (Month) 24 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1943, to Jan 24, 1944

I last saw h[illegible] alive on Jan 22, 1944, death is said to have occurred on the date stated above, at 6.30 p.m.

Immediate cause of death ..... Duration IMPORTANT

Hypertrophic chronic 5-

Due to Arteriosclerosis chronic 2-

Due to .....

Other conditions (Include pregnancy within 3 months of death) unk IMPORTANT

Major findings: Of operations unk Date of .....

Of autopsy unk

What test confirmed diagnosis? Physical exam

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Edward J Courtney, M. D.

(Address) 9 Central Marlboro Date Jan 24 1944

21 Immaculate Conception Marlboro Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Jan 26 1944

22 NAME OF FUNERAL DIRECTOR John F Brown

ADDRESS 95 W Main St Marlboro

Received and filed ..... 19.....

(Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100M-6-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. /

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Boston Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Sarah Cordelia (Fletcher) Brewer (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Boston St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months days. (Specify whether) In this community 35 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Walter B. Brewer (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive 52 years

7 IF STILLBORN, enter that fact here.

8 AGE 48 Years 0 Months 6 Days | If less than 1 day Hours Minutes

9 Usual Occupation: At home

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country): Milford Mass.

PARENTS

13 NAME OF FATHER: George Fletcher

14 BIRTHPLACE OF FATHER (City) (State or country): Milford Mass.

15 MAIDEN NAME OF MOTHER: Sarah Cheney

16 BIRTHPLACE OF MOTHER (City) (State or country): Mendon Mass.

17 Informant (Address): Walter B. Brewer Boston Rd., Southboro — Relation, if any: (Husband)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James J. Peters
(Signature of Agent of Board of Health or other)

Burial Agent
(Official Designation)

Jan. 30, 1944
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: January (Month) 30 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1936, to January 30, 1944

I last saw her alive on June 30, 1944, death is said to have occurred on the date stated above, at 5 A m.

Immediate cause of death: Arteriosclerosis — Duration IMPORTANT — 7 — years

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death): none — IMPORTANT

Major findings:
Of operations: none — Date of:
Of autopsy: not
What test confirmed diagnosis? Physical exam

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Edward C. Stevenson, M. D.
(Address) Central Worcester Date Jan 30 1944

21 Rural Cemetery Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL February 2, 1944

22 NAME OF FUNERAL DIRECTOR Sumner G. Gage
ADDRESS 15 Cotting Ave., Marlboro

Received and filed 19
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

MIDDLESEX (County)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. .....

1 PLACE OF DEATH: MARLBOROUGH (City or Town) No. Marl Hosp St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Sarah Marshall (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Main St. St. Southboro Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): wid

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Alba Marshall (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 88 Years 3 Months 8 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: housework

10 Industry or Business: own home

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) .....

PARENTS

13 NAME OF FATHER: Caleb S. Williams

14 BIRTHPLACE OF FATHER (City) Southboro (State or country) Mass

15 MAIDEN NAME OF MOTHER: Sarah F. Walkup

16 BIRTHPLACE OF MOTHER (City) cannot be learned (State or country)

17 Informant: Rev Robert Cheney (Relation, if any) Pastor (Address) Southboro Mass

A TRUE COPY. ATTEST: Charles F. Wade (Registrar of city or town where death occurred)

DATE FILED Feb 8 1944 19.....

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Feb 7 1944 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1944, to Feb 7, 1944
I last saw her alive on Feb 7, 1944 death is said to have occurred on the date stated above, at 11.50 P.M.

Immediate cause of death	Duration
carcinoma of liver	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations ..... Date of	
Of autopsy Xray and Phys Ex	
What test confirmed diagnosis?	

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Clyde H. Merrill M. D.
(Address) Marlborough Mass Date 2-8-, 19 44

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Southboro (Cemetery) (City or Town)
DATE OF BURIAL Feb 10 1944 19.....

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlboro Mass

Received and filed April Feb 10 1944 19.....
Maizie F. Wizard
(Registrar of City or Town where deceased resided)

ORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-'39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No. .....

1 PLACE OF DEATH: WORCESTER (County); WORCESTER (City or Town)

No. The Memorial Hosp St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice M (Unknown) Benson (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Pearl St. Southboro (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution Hosp (Specify whether) years months 20 days. In this community yrs. mos. days.

15h 10m

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Harry G Benson (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 74 Years 11 Months 1 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At home

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Lowell

PARENTS

13 NAME OF FATHER (Cannot be learned)

14 BIRTHPLACE OF FATHER (City) (State or country) (Cannot be learned)

15 MAIDEN NAME OF MOTHER (Cannot be learned)

16 BIRTHPLACE OF MOTHER (City) (State or country) (Cannot be learned)

17 Informant Harry G Benson (Address) Southboro (Relation, if any) Husband

A TRUE COPY.
ATTEST: Malcolm C McLaughlin
(Registrar of city or town where death occurred)

DATE FILED Feb 14 19 44

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb 9, 1944 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 19, 19 44, to Feb 9, 19 44

I last saw her alive on Feb 8, 19 44 death is said to have occurred on the date stated above, at 2.30 a.m.

Immediate cause of death	Duration
Senility	
Due to Cerebral arteriosclerosis	yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) R W Cutler, M. D.
(Address) Worcester Date 2-9 19 44

21 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Everett
(Cemetery) (City or Town)
DATE OF BURIAL 2-11 19 44

22 NAME OF FUNERAL DIRECTOR George H Longstreet
ADDRESS Worcester

Received and filed ..... 19 .....
(Registrar of City or Town where deceased resided)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

100m-10-'39. No. 8427-e

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No.

No. Baker's Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Henry Kennedy (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. 61 Washington St. Marlboro, Mass. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of Mary Ellen Sullivan (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years 11 Months 15 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Shoemaker

10 Industry or Business: Retired

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Marlboro Mass.

PARENTS

13 NAME OF FATHER: Michael Kenney

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Unobtainable

16 BIRTHPLACE OF MOTHER (City) (State or country): Unobtainable

17 Informant (Address): John Kennedy Son Brand St Marlboro Mass. Relation, if any

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Felter (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Feb. 17. 44 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Feb (Month) 15 (Day) 1944 (Year)

19 I HEREBY CERTIFY That I attended deceased from Jan 3, 1938, to Feb 15, 1944
I last saw h.e.s. alive on Feb 14, 1944, death is said to have occurred on the date stated above, at 2 P m.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: IMPORTANT Yrs

Due to: Senile Debility — Duration: Yrs

Due to: — Duration:

Other conditions: Bilateral Hernias — Duration: Yrs
(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Date of:
Of autopsy: None
What test confirmed diagnosis? Phy Exam

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) H. Monroe Foster M. D.
(Address) Northboro Mass. Date 4/7 1944

21 Interment Cemetery Worcester Co. Crematory Marlboro.
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL Feb 18 1944

22 NAME OF FUNERAL DIRECTOR John P. Power
ADDRESS Marlboro, Mass.

Received and filed 19
(Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100M-E-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Marlboro Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Herman Monnette
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence. No. Marlboro Rd Southboro Mass St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 54 yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Rose Laporte
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive 47 years

7 IF STILLBORN, enter that fact here.

8 AGE 54 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Baker

10 Industry or Business: Food Shop

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Hudson Mass

PARENTS

13 NAME OF FATHER Stephen Monnette

14 BIRTHPLACE OF FATHER (City) (State or country) Canada

15 MAIDEN NAME OF MOTHER Edwire Lusignan

16 BIRTHPLACE OF MOTHER (City) (State or country) Southbridge Mass

17 Informant (Address) Rose Monnette Southboro Mass (Relation, if any) Wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Leeher
(Signature of Agent of Board of Health or other)

Burial Agent March 8, 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March (Month) 7 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from March 1, 1944, to March 7, 1944

I last saw him alive on March 7, 1944 death is said to have occurred on the date stated above, at 12.45 P. m.

	Duration
Immediate cause of death	IMPORTANT
Chronic myocarditis	
Lobar Pneumonia,	2-27-44
Due to	
.....	
Due to	
.....	
Other conditions Bronchial Cathma (include pregnancy within 3 months of death)	5 & 10 yrs
	IMPORTANT
Major findings: Of operations ..... Date of	Physician Underline the cause to which death should be charged statistically.
Of autopsy	
What test confirmed diagnosis?	

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Albert E. LeMaire M. D.
(Address) Marlboro Date 3-7- 1944

21 Burial Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 10 1944

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed March 9 1944
Margaret T. Hannaford asst
(Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100M-6-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southbero; No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth (Bowler) Trigeau
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 19 Beach St Greenfield Mass St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution Rest Home years 3 months days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Amadee Trigeau
(Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At Home

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Waltham Mass

PARENTS

13 NAME OF FATHER Patrick Bowler

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER can not be learned

16 BIRTHPLACE OF MOTHER (City) " " " "
(State or country)

17 Informant Gus Langdon (Relation, if any) Cousin
(Address) Marlboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Fallon
(Signature of Agent of Board of Health or other)

Agent
(Official Designation)

March 14 1944
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March (Month) 12 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1944 to March 12, 1944
I last saw h[e] alive on Mar 11, 1944, death is said to have occurred on the date stated above, at 30 A m.

Immediate cause of death Arterio Sclerosis
Due to Hypertension

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations None
Date of .....
Of autopsy None
What test confirmed diagnosis? Physical Signs

Duration
IMPORTANT
1 yr.

IMPORTANT
Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Jas F Fallon M.D.
(Address) Marlboro Mass Date Mar 12, 1944

21 Calvary Waltham Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 14 1944

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed March 13 1944
Registrar

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-10-'39. No. 8427-i

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No.....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Melindy Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME David E. Stone (If U. S. War Veteran, specify WAR).....
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. 120 Maynard Road St. Framingham
(Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution ..... years months days. In this community 30 yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of Ada Foye
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive.....years

7 IF STILLBORN, enter that fact here.

8 AGE 82 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Carpenter

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) Tobee Rivers, Quebec
(State or country) Canada

PARENTS

13 NAME OF FATHER Unknown

14 BIRTHPLACE OF FATHER (City) Unknown
(State or country) "

15 MAIDEN NAME OF MOTHER Unknown

16 BIRTHPLACE OF MOTHER (City) Unknown
(State or country) "

17 Informant Harold Farrar Relation, if any .....
(Address) Framingham, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Telfer
(Signature of Agent of Board of Health or other)

Burial Agent. March 8. 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 27 1944
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify).....

Date of occurrence.....19.....

Where did Injury occur?.....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, in public place?.....
(Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work?.....Was there an autopsy?.....

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter F. Hutchinson, M. D.

(Address) Westborough Date Mar 27 1944

22 Pine Hill—Hoover, N. H.
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL March 29, 1944

23 NAME OF FUNERAL DIRECTOR E. A. Cookson

ADDRESS 318 Union Ave., Framingham

Received and filed May 22 1944

Marjorie F. McBeard
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southborough; No. Framingham Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Francis Gregory Fay (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Framingham Road St. Southborough (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution 5 years (Specify whether) months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

5a If married, widowed, or divorced HUSBAND of Evelyn J. Ellis (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years 7 Months 15 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Farmer

10 Industry or Business:

11 Social Security No. none

12 BIRTHPLACE (City) Southborough (State or country) Mass.

PARENTS

13 NAME OF FATHER Francis A Fay

14 BIRTHPLACE OF FATHER (City) Southborough (State or country) Mass

15 MAIDEN NAME OF MOTHER Flora A Lawrence

16 BIRTHPLACE OF MOTHER (City) Marlborough (State or country) Mass

17 Informant (Address) Francis Fay Southboro Mass Relation, if any (brother)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Agent
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April 1 1944 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from March 1944, to April 1, 1944

I last saw him alive on March 31, 1944, death is said to have occurred on the date stated above, at 8:20 A.M.

	Duration
Immediate cause of death: Myocardial insufficiency	3
Due to Arterio sclerosis chronic	2
Due to	
Other conditions (Include pregnancy within 3 months of death) Senile enteritis	2 days

Major findings:
Of operations none
Date of
Of autopsy none
What test confirmed diagnosis? Physical exam

PHYSICIAN — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Edward L Sanders, M. D.
(Address) 9 Federal Northboro Mass Date Apr 1 1944

21 Burial Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 4 1944

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed April 13 1944

A TRUE COPY ATTEST: Marjorie F. McDonald (Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southborough; No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Allan Hosea Draper (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Main St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution ..... years months days. (Specify whether) In this community 70 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of Alice May Olmsted (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 68 years

7 IF STILLBORN, enter that fact here.

8 AGE 76 Years 0 Months 10 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Contractor

10 Industry or Business: general

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Marlborough Mass

PARENTS

13 NAME OF FATHER: Samuel Fisher Draper

14 BIRTHPLACE OF FATHER (City) (State or country) Brookfield Mass

15 MAIDEN NAME OF MOTHER: Mary Louisa Howe

16 BIRTHPLACE OF MOTHER (City) (State or country) Marlborough Mass

17 Informant (Address) Mrs. Alice M. Draper (Main St.) Relation, if any wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Agent. April 10-1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 10 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to April 10, 1944

I last saw h.. alive on April 9, 1944, death is said to have occurred on the date stated above, at 1.30 A. m.

	Duration
Immediate cause of death: Coronary thrombosis	3 years
Due to Arterio sclerosis	7-
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations none Date of

Of autopsy none

What test confirmed diagnosis? Clinical symptoms

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Roland L. Morton, M. D.

(Address) 9 Central Westboro Mass Date April 10 1944

21 Place of Burial, Cremation or Removal. Marlwood Marlboro (City or Town)

DATE OF BURIAL April 12 1944

22 NAME OF FUNERAL DIRECTOR Dunner & Gage

ADDRESS 15 Cottage Ave. Marlboro

Received and filed April 13 1944

Maurice F. McDonald
A TRUE COPY ATTEST: (Registrar)

FORM R-305

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-10-39. No. 8427-g

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No.....

1 PLACE OF DEATH: WORCESTER (County) WORCESTER (City or Town)

No. Worc City Hosp St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles E Adams (If deceased is a married, widowed or divorced woman, give also maiden name.)

(If U. S. War Veteran, specify WAR).....

(a) Residence. No. --- St. Southboro (If nonresident, give city or town and state)

Length of stay: In hospital or institution yes (Specify whether) years months 17h days. In this community 4 yrs. 6 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Mary L Ginga (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 31 years

7 IF STILLBORN, enter that fact here.

8 AGE 36 Years - Months 16 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Coal Dealer

10 Industry or Business: Coal & Fuel

11 Social Security No.....

12 BIRTHPLACE (City) Sudbury (State or country)

PARENTS

13 NAME OF FATHER Charles Adams

14 BIRTHPLACE OF FATHER (City) ..... (State or country) Italy

15 MAIDEN NAME OF MOTHER Julia Piccinotti

16 BIRTHPLACE OF MOTHER (City) ..... (State or country) Italy

17 Informant Mary L Adams Relation, if any (Widow)
(Address) Southboro

A TRUE COPY.
ATTEST: Malcolm E McSley
(Registrar of city or town where death occurred)
DATE FILED Apr 15 19 44

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Apr 13, 1944 (Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture of skull

20 Accident, suicide, or homicide (specify) Accident

Date of occurrence 4-12 19 44

Where did Injury occur? Southboro (Fayville) (City or town and State)

Did injury occur in or about the home, on farm, in industrial place, or in public place? home (Specify type of place)

Manner of Injury Fell struck head on bathtub

Nature of Injury Fracture of skull

While at work? no Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) John C Ward M. D.

(Address) Worcester Date 4-13 19 44

22 Rural Cem Southboro (Place of Burial, Cremation or Removal) (City or Town)

DATE OF BURIAL Apr 17 19 44

23 NAME OF FUNERAL DIRECTOR John A Cunningham

ADDRESS Framingham

Received and filed May 15, 1944 19

(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

MIDDLESEX (County)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MARLBOROUGH (City or town making return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: (County) MIDDLESEX; (City or Town) MARLBOROUGH; No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas Leslie LePage (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Latisquama Road (Usual place of abode) Southboro Mass (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) 6 dys (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced HUSBAND of Ruth A. Maynard (Give maiden name of wife in full) (or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 42 years

7 IF STILLBORN, enter that fact here.

8 AGE 64 Years - 16 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: contractor building houses

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Summerside P E I

PARENTS

13 NAME OF FATHER: John LePage

14 BIRTHPLACE OF FATHER (City) (State or country): P E I

15 MAIDEN NAME OF MOTHER: Sarah Strang

16 BIRTHPLACE OF MOTHER (City) (State or country): P E I

17 Informant (Address) Ruth A. LePage Latisquama Rd Southboro Relation (wife)

A TRUE COPY. F. J. Bertrand

ATTEST: ..... (Registrar of city or town where death occurred)

DATE FILED Apr 20 1944

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 16 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 21, 1942 to Apr 16, 1944

I last saw him alive on Apr 16 1944, death is said to have occurred on the date stated above, at 8.15 P.M.

Immediate cause of death — Duration

Coronary thrombosis 7 dys

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations ..... Date of .....

Of autopsy .....

What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) Albert E. LeMarbre, M. D.

(Address) Marlboro 4-17-44 Date 19.....

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cem Southboro (Cemetery) (City or Town)

DATE OF BURIAL Apr 19 1944 19.....

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Cotting Ave City

Received and filed Apr 19 44

(Registrar of City or Town where deceased resided)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. ....

1 PLACE OF DEATH
Worcester (County)
Southborough (City or Town)
No. Melendy Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward J. Morton
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 581 Concord St. Framingham
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Rest Home years 3 months days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS	
3 SEX	male
4 COLOR OR RACE	white
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)	Widowed
5a If married, widowed or divorced HUSBAND of (Give maiden name of wife in full)	Harriet Burke
(or) WIFE of (Husband's name in full)	
6 Age of husband or wife if alive ... years	
7 IF STILLBORN, enter that fact here.	
8 AGE	84 Years 2 Months 13 Days; If less than 1 day ... Hours ... Minutes
9 Usual Occupation	Unknown
10 Industry or Business	"
11 Social Security No.	None
12 BIRTHPLACE (City) (State or country)	Romeo, Michigan
PARENTS: 13 NAME OF FATHER	George B. Morton
14 BIRTHPLACE OF FATHER (City) (State or country)	Unknown
15 MAIDEN NAME OF MOTHER	Francis A. Malhary
16 BIRTHPLACE OF MOTHER (City) (State or country)	Unknown
17 Informant (Address)	Marion Morrell, Arlington, Mass. Relation, if any (Cousin)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
James J. Telfer
(Signature of Agent of Board of Health or other)
Agent (Official Designation) — May 2, 1944 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH	
18 DATE OF DEATH	May (Month) 2 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 12, 1944, to May 2, 1944
I last saw him alive on April 29, 1944, death is said to have occurred on the date stated above, at ....m.

	Duration
Immediate cause of death. Myocarditis chronic	-?-
Due to Arterio sclerosis chronic	-?-
Due to	

IMPORTANT

Other conditions Colitis chronic
(Include pregnancy within 3 months of death)

Major findings:
Of operations Amputation leg - mid thigh - [illegible] Date of
Of autopsy none
What test confirmed diagnosis? Physical exam

IMPORTANT — Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Roland [illegible] M. D.
(Address) Westboro Date May 2 1944

21 Pine Hill Cemetery, Sherborn
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL May 4 1944

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS Framingham, Mass.

Received and filed May 3 1944
[illegible] (Registrar)

100M-E-2-42-8855

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

Registered No. .....

(City or town making return) .....

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southbridge; No. Leesville; St. Baker Rest Home

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. Josepha Filion

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If U. S. War Veteran specify WAR) .....

(a) Residence. No. 29 Orchard St. .....

(Usual place of abode)

(If nonresident, give city or town and state) .....

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.

(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of Philomette Mailhiot
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 75 Years / Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Shoe cutter

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) St Roch PQ

PARENTS

13 NAME OF FATHER Napoleon Filion

14 BIRTHPLACE OF FATHER (City) (State or country) St. Roch PQ

15 MAIDEN NAME OF MOTHER MARIE E MOND

16 BIRTHPLACE OF MOTHER (City) (State or country) St. Roch PQ

17 Informant Delsia A Lange (Address) ..... Relation, if any (daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Telfer
(Signature of Agent of Board of Health or other)

Agent
(Official Designation)

May 5, 1944
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May (Month) 3 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1944, to May 3, 1944

I last saw h... alive on May 2, 1944, death is said to have occurred on the date stated above, at 9:30 A.m.

	Duration
Immediate cause of death: Myocardial Insufficiency	-3-
Due to Arterio sclerosis Chronic	-3-
Due to	
Other conditions (Include pregnancy within 3 months of death) Nephritis Chronic	

Major findings:
Of operations none
Date of .....
Of autopsy none
What test confirmed diagnosis? Physical examination

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Roland A Vaudreuil, M. D.

(Address) Southbridge Date May 3 1944

21 St Marys Cemetery Marlboro
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL May 1944

22 NAME OF FUNERAL DIRECTOR Henry A Harbin
ADDRESS 93 Broad St Marlboro

Received and filed May 22 1944

A TRUE COPY ATTEST: Marguerite F. Hibbard
(Registrar)

RM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(e)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registrar's No. _____

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Hammond St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ruth Naomi (Stockemer) Bean
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Hammond St.
(Usual place of abode)
(If nonresident, give city or town and State)

Length of stay: In hospital or Institution _____ years _____ months _____ days. (Before death) (Specify whether)
In this community 30 yrs. _____ mos. _____ days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)
(or) WIFE of Chester M. Bean
(Husband's name in full)

6 Age of husband or wife if alive _____ years

7 IF STILLBORN, enter that fact here.

8 AGE 55 Years 10 Months _____ Days | If less than 1 day: _____ Hours _____ Minutes

9 Usual Occupation: At home

10 Industry or Business: _____

11 Social Security No. _____

12 BIRTHPLACE (City) (State or country): South Boston Mass

PARENTS

13 NAME OF FATHER: Charles H. Stockemer

14 BIRTHPLACE OF FATHER (City) (State or country): Connecticut

15 MAIDEN NAME OF MOTHER: Charlotte Bevans

16 BIRTHPLACE OF MOTHER (City) (State or country): Boston Mass.

17 Informant (Address): Chester M. Bean Hammond St. Southboro (Relation, if any): Husband

was filed with me BEFORE the burial or transit permit was issued:
I HEREBY CERTIFY that a satisfactory standard certificate of death

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agent. May 12, 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: May (Month) 9 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from _____, 19 26, to May 9, 19 44
I last saw her alive on May 9, 19 44 death is said to have occurred on the date stated above, at 12.38 P.M.

	Duration
Immediate cause of death: Cerebral Hemorrhage	IMPORTANT 6½ hours
Due to: Arteriosclerosis and hypertention	7 years
Due to:	
Other conditions (Include pregnancy within 3 months of death)	IMPORTANT
Major findings: Of operations	Physician
Date of	Underline the cause to which death should be charged statistically.
Of autopsy	
What test confirmed diagnosis?	

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) H. E. Gove, M. D.
(Address) 76 Main St, Ashland Date May 9-44

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 12, 1944

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS Marlboro, Mass.

Received and filed May 22 1944
Marguerite M. Bernard
(Registrar)

FORM R-305

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m (h)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 121

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town); No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Beulah Adelaide Baker (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Ward Rd Southboro St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution (Before death) XXXXXXXXX (Specify whether) years 2 months 24 days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Arthur L. Baker (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 63 Years 8 Months 21 Days | If less than 1 day Hours Minutes

9 Usual Occupation: housework

10 Industry or Business: own home

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Brooklyn N.Y.

PARENTS

13 NAME OF FATHER: Walter S. King

14 BIRTHPLACE OF FATHER (City) (State or country): Philadelphia Penn

15 MAIDEN NAME OF MOTHER: Caroline Gilday

16 BIRTHPLACE OF MOTHER (City) (State or country): Charlestown Mass

17 Informant (Address) Arthur L. Baker Ward Rd. Southboro (Husband, if any)

A TRUE COPY.
ATTEST: F. J. Bertrand
(Registrar of city or town where death occurred)
DATE FILED May 29 1944

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May 24 1944 (Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

arteriosclerotic heart disease
concussion of brain
lac of scalp & multiple abrasions

20 Accident, suicide, or homicide (specify) accident
Date of occurrence May 21 1944 19
Where did Injury occur? Marlboro Mass (City or town and State)
Did injury occur in or about the home, on farm, in industrial place, or in public place? Marlboro Hosp (Specify type of place)
Manner of Injury fell 16 feet from window
Nature of Injury concussion of brain & multiple injuries
While at work? no Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) William D. Roche, M. D.
(Address) Marlborough Mass 5-25-44

22 Rural Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 27 1944 19

23 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlborough Mass

Received and filed 19
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Stoneham
(City or town making return)

Registered No. 86

1 PLACE OF DEATH: Middlesex (County); Stoneham (City or Town); No. 114 Franklin St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Willie Dow Green
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If U. S. War Veteran, specify WAR) no

(a) Residence. No. Fayville St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. (Before death) (Specify whether)
In this community yrs. 6 mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 57 Years 8 Months 11 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Carpenter

10 Industry or Business: .....

11 Social Security No. 015-16-2914

12 BIRTHPLACE (City) (State or country): Southboro Massachusetts

PARENTS

13 NAME OF FATHER: Walter Green

14 BIRTHPLACE OF FATHER (City) (State or country): Wakefield (Greenwood) Massachusetts

15 MAIDEN NAME OF MOTHER: Anna Dow

16 BIRTHPLACE OF MOTHER (City) (State or country): Stoneham Massachusetts

17 Informant: Frank E. Green (Relation, if any: Brother)
(Address) 114 Franklin St., Stoneham, Mass.

A TRUE COPY. ATTEST: Winthrop A. McCarthy
(Registrar of city or town where death occurred)

DATE FILED June 19, 1944

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: June (Month) 16, (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1944, to June 16, 1944
I last saw him alive on June 9, 1944, death is said to have occurred on the date stated above, at 1:00 p. m.

Immediate cause of death ..... Duration
Chronic Myocarditis 1943
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) .....
Major findings: Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Antonio L. Tauro, M. D.
(Address) Stoneham, Mass. Date 6/16 1944

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Lindenwood Cem., Stoneham
(Cemetery) (City or Town)
DATE OF BURIAL June 18, 1944

22 NAME OF FUNERAL DIRECTOR: Charles W. Messer & Son
ADDRESS: Stoneham, Mass.

Received and filed June 30 1944
Winthrop A. McCarthy
(Registrar of City or Town where deceased resided)

M R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(e)-3-43-11574

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Central Street, Southboro. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registrar's No. _____

2 FULL NAME Irving Sylvester Hosmer
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) _____

(a) Residence. No. Central Street St. Southboro.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution _____ years _____ months _____ days. In this community 74 yrs. _____ mos. _____ days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of Nellie Canty
(Give maiden name of wife in full)
(or) WIFE of _____
(Husband's name in full)

6 Age of husband or wife if alive 70 years

7 IF STILLBORN, enter that fact here.

8 AGE 74 Years 1 Months 7 Days | If less than 1 day _____ Hours _____ Minutes

9 Usual Occupation: Farmer

10 Industry or Business: _____

11 Social Security No. _____

12 BIRTHPLACE (City) (State or country) Southboro Mass.

PARENTS

13 NAME OF FATHER: Sylvester G. Hosmer

14 BIRTHPLACE OF FATHER (City) (State or country): Southboro Mass.

15 MAIDEN NAME OF MOTHER: Abby A. Forrister

16 BIRTHPLACE OF MOTHER (City) (State or country): Framingham Mass.

17 Informant (Address): Arthur Hosmer Southboro, Mass. Relation, if any: Son

was filed with me BEFORE the burial or transit permit was issued:
I HEREBY CERTIFY that a satisfactory standard certificate of death

James Tucker
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) July 12, 44 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 10 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 18, 1943, to July 10, 1944
I last saw him alive on July 10, 1944 death is said to have occurred on the date stated above, at 3:15 P.M.

	Duration
Immediate cause of death: uremia	IMPORTANT 3 wks
Due to: urinary obstruction	2 months
Due to: Ca prostate with generalized metastases	3 yrs
Other conditions (Include pregnancy within 3 months of death)	IMPORTANT
Major findings: Of operations	Physician
Date of	Underline the cause to which death should be charged statistically.
Of autopsy	
What test confirmed diagnosis? X-ray	

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Hugh Folsom, M. D.
(Address) 198 Union Ave Framingham Date July 11 1944

21 Rural Cemetery Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 13 1944

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS 318 Union Ave., Framingham.

Received and filed _____ 19____
(Registrar)

ORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(e)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registrar's No. _____

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Newton St. — (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) _____

2 FULL NAME Emma A {Bouthillet} Hurley
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Newton St Southboro St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution _____ years _____ months _____ days. (Before death) (Specify whether) In this community 15 yrs. _____ mos. _____ days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Widowed

5a If married, widowed, or divorced
HUSBAND of _____ (Give maiden name of wife in full)
(or) WIFE of Timothy Hurley (Husband's name in full)

6 Age of husband or wife if alive _____ years

7 IF STILLBORN, enter that fact here.

8 AGE 74 Years _____ Months _____ Days | If less than 1 day _____ Hours _____ Minutes

9 Usual Occupation: At Home

10 Industry or Business: _____

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Burlington Vt

PARENTS

13 NAME OF FATHER: Ulderic Bouthillet

14 BIRTHPLACE OF FATHER (City) (State or country): Canada

15 MAIDEN NAME OF MOTHER: Caroline E Lamere

16 BIRTHPLACE OF MOTHER (City) (State or country): Canada

17 Informant (Address): Ulderic Hurley Newton St Southboro — Relation, if any: Son

was filed with me BEFORE the burial or transit permit was issued:
I HEREBY CERTIFY that a satisfactory standard certificate of death

James Telfer
(Signature of Agent of Board of Health or other)

Burial Agent July 21 44
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: July (Month) 21 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 27, 1944, to July 21, 1944
I last saw her alive on July 20 1944 death is said to have occurred on the date stated above, at 7 A.M.

	Duration — IMPORTANT
Immediate cause of death: Myocarditis	1 year
Due to: Arteriosclerosis	2 years
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

IMPORTANT

Major findings: Of operations: —
Date of: —
Of autopsy: —
What test confirmed diagnosis? None

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Thomas C Reilly, M. D.
(Address) Marlboro, Mass Date July 21 1944

21 St Michel Hudson
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 24 1944

22 NAME OF FUNERAL DIRECTOR John M Tighe
ADDRESS Marlboro Mass

Received and filed _____ 19____
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

TEWKSBURY STATE HOSPITAL and INFIRMARY
TEWKSBURY, MASSACHUSETTS
(City or town making return)

Registered No. 279

1 PLACE OF DEATH: Middlesex (County); Tewksbury, Mass. (City or Town); No. Tewksbury State Hospital and Infirmary St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Antonio Zarega (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Mill Street, St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) 0 years 0 months 9 days. In this community yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of Not learned (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years 4 Months 4 Days | If less than 1 day ... Hours ... Minutes

9 Usual Occupation: Laborer

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country): Not learned, Italy

PARENTS

13 NAME OF FATHER: Augustino Zarega

14 BIRTHPLACE OF FATHER (City) (State or country): Not learned, Italy

15 MAIDEN NAME OF MOTHER: Kate (not learned)

16 BIRTHPLACE OF MOTHER (City) (State or country): Not learned, Italy

17 Informant (Address): Hospital Records (Relation, if any)

A TRUE COPY. ATTEST: C. Winthrop Houghton M.D. Supt.
(Registrar of city or town where death occurred)

DATE FILED August 12 19 44

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: August (Month) 12 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1944, to Aug. 12, 1944
I last saw him alive on Aug. 12, 1944 death is said to have occurred on the date stated above, at 4:15 A.m.

	Duration
Immediate cause of death: Terminal Bronchopneumonia	24 hrs
Due to: Arteriosclerotic Heart Disease	Yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ... Date of ...
Of autopsy ...
What test confirmed diagnosis? Clinical

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? ...
If so, specify ...
(Signed) Nils E. Svibergson, M. D.
(Address) T. S. H. and I., Tewksbury Date 8-12 19 44

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cem., Southboro (Cemetery) (City or Town)
DATE OF BURIAL August 14 19 44

22 NAME OF FUNERAL DIRECTOR William Tighe
ADDRESS Windsor St., Marlboro, Mass.

Received and filed ... 19 ...
(Registrar of City or Town where deceased resided)

ORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-E-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Middlesex (County) — Southboro (City or Town) — No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Alvah D. Spencer (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 568 Main Street St. Hudson, Mass. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution 1 years months days. In this community yrs. 6 mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ale
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced HUSBAND of Linnie J. Harford (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 65 years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 11 Months 29 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired Mill Worker

10 Industry or Business: .....

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Sanford Maine

PARENTS

13 NAME OF FATHER Samuel L. Spencer

14 BIRTHPLACE OF FATHER (City) (State or country) Sanford Maine

15 MAIDEN NAME OF MOTHER Sarah Norman

16 BIRTHPLACE OF MOTHER (City) (State or country) Maine

17 Informant (Address) Alfred A. Spencer 568 Main St. Hudson, Mass. (Relation, if any) Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Sexton
(Signature of Agent of Board of Health or other)

Burial Agt. August 13, 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH August (Month) 13 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1944, to Aug 13, 1944

I last saw him alive on Aug 13, 1944, death is said to have occurred on the date stated above, at 3.30 P. m.

Duration

Immediate cause of death
Myocarditis Chronic — IMPORTANT

Due to Arteria sclerosis — -2-

Due to .....

Other conditions. Hypertrophy prostate
(Include pregnancy within 3 months of death)
Cystitis Chronic. — IMPORTANT

Major findings:
Of operations None
Date of .....
Of autopsy None
What test confirmed diagnosis? Physical Exam

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Roland S. Newton, M. D.
(Address) Westboro Mass. Date Aug 13 1944

21 Prospect Cem. Epping, N. H.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL August 15, 1944 19

22 NAME OF FUNERAL DIRECTOR Edward L. Merrill
ADDRESS 1 Pleasant St. Hudson, Mass.

Received and filed Aug 2 9 19 44
Winifred T. McDonald
(Registrar)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-2-40-D-729-b

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No.....

1 PLACE OF DEATH: Worcester (County) / Southville (City or Town)

No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Patrick Henry O'Brien (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR).....

(a) Residence. No. Southville Rd St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. (Specify whether) In this community 77 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of..... (Give maiden name of wife in full)
(or) WIFE of..... (Husband's name in full)

6 Age of husband or wife if alive.....years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years 5 Months 8 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Ticket Agent (Retired)

10 Industry or Business: B & A R.R.

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Southville Massachusetts

PARENTS

13 NAME OF FATHER: Patrick O'Brien

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Mary O'Brien

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address): Mrs. Julia Tucker Westboro Mass. Relation, if any: (sister)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Fuller (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) August 29 1944 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: August (Month) 20 (Day) 1944. (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cause of Death: Natural Presumably
Coronary Occlusion
Contributory Cause Hypertension Heart Disease

20 Accident, suicide, or homicide (specify).....
Date of occurrence No 19.....

Where did Injury occur?..... (City or Town and State)

Did injury occur in or about home, on farm, in industrial place, in public place?
No
(Specify type of place)

Manner of Injury ?

Nature of Injury ?

While at work?..... Was there an autopsy?.....

21 Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Frederick W Sands MD, M. D.

(Address) Southboro Mass Date Aug 30 19 44.

22 St. Johns Hopkinton
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL August 23 19 44

23 NAME OF FUNERAL DIRECTOR F. H. Callaghan Son
ADDRESS Hopkinton, Mass

Received and filed Aug 29 19 44

Registrar

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Easton (City or town making return)

Registered No. 45

1 PLACE OF DEATH: Bristol (County); Easton (City or Town); No. 231 Main St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Penelope (Allanach) Tulloch (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Sears Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community yrs. 2 mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of John Tulloch (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 4 Months 6 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired housewife

10 Industry or Business: At home

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country): Scotland

PARENTS

13 NAME OF FATHER: John Allanach

14 BIRTHPLACE OF FATHER (City) (State or country): Scotland

15 MAIDEN NAME OF MOTHER: Jane Burridge

16 BIRTHPLACE OF MOTHER (City) (State or country): Scotland

17 Informant: John Allanach (Address) Marion, Conn. (Relation, if any): Nephew

A TRUE COPY. ATTEST: John W. Smith (Registrar of city or town where death occurred)

DATE FILED August 24, 1944

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: August (Month) 23, (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 3, 1944, to Aug. 23, 1944, I last saw her alive on Aug. 23, 1944, death is said to have occurred on the date stated above, at 9.10 P. m.

Duration

Immediate cause of death: Carcinoma of Pancrease — 6Mos.

Due to .....

Due to .....

June 29, 1944

Other conditions (Include pregnancy within 3 months of death): Fractured right femur

Major findings: Of operation: Carcinoma of Pancrease Date of Apr. 1944

Of autopsy .....

What test confirmed diagnosis? Physical

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No. If so, specify .....

(Signed) Jacob Brenner, M. D.
(Address) N. Easton, Mass. Date Aug. 29, 1944

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Rural, Southboro (Cemetery) (City or Town)
DATE OF BURIAL August 26, 1944

22 NAME OF FUNERAL DIRECTOR: Sumner C. Gage
ADDRESS 15 Cotting Ave. Marlboro

Received and filed ..... 19 .....
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

TEWKSBURY STATE HOSPITAL and INFIRMARY
TEWKSBURY, MASSACHUSETTS
(City or town making return)

Registered No. 319

1 PLACE OF DEATH
Middlesex (County)
Tewksbury, Mass. (City or Town)
No. Tewksbury State Hospital and Infirmary St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Flora Berni (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) ———

(a) Residence. No. ——— St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) 25 years 1 months 9 days. In this community yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lazzero Berni (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive Not learned years

7 IF STILLBORN, enter that fact here.

8 AGE 59 Years 11 Months 14 Days | If less than 1 day ... Hours ... Minutes

9 Usual Occupation: Housewife

10 Industry or Business:

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Metti Italy

PARENTS

13 NAME OF FATHER: Edward Turby

14 BIRTHPLACE OF FATHER (City) (State or country) Not learned Italy

15 MAIDEN NAME OF MOTHER: Not Learned

16 BIRTHPLACE OF MOTHER (City) (State or country) Not learned Italy

17 Informant (Address) Hospital Records (Relation, if any)

A TRUE COPY.
ATTEST: C. Whittemore Houghton M.D. Supt.
(Registrar of city or town where death occurred)
DATE FILED September 18, 1944

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH September (Month) 18 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1940, to Sept. 18, 1944, I last saw her alive on Sept. 18, 1944, death is said to have occurred on the date stated above, at 9:55 P. m.

	Duration
Immediate cause of death: Bronchial Pneumonia with Pleural Effusion	3 wks.
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: Date of:	
Of autopsy: What test confirmed diagnosis? Clinical	

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) H. R. Plunkett, M. D.
(Address) T. S. H. and I., Tewksbury Date 9-10 1944

21 PLACE OF BURIAL, CREMATION OR REMOVAL Calvary Cem., Boston (Cemetery) (City or Town)
DATE OF BURIAL September 22 1944

22 NAME OF FUNERAL DIRECTOR M. J. Porcella
ADDRESS 10 No. Bennet St., Boston

Received and filed Sep. 11 1944
Margaret T. McDonald
(Registrar of City or Town where deceased resided)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro

No. Clifford St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Franklin Field. (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Clifford Rd. St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution —0— years months days. In this community 35 yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Juliette Wright. (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 78 years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years 10 Months 17 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired — Sales man

10 Industry or Business: Wholesale grocer

11 Social Security No. No

12 BIRTHPLACE (City) (State or country) Malden Mass

PARENTS

13 NAME OF FATHER Frank Field

14 BIRTHPLACE OF FATHER (City) (State or country) unknown

15 MAIDEN NAME OF MOTHER Almira Tilly

16 BIRTHPLACE OF MOTHER (City) (State or country) unknown

17 Informant (Address) Juliette Field, Clifford Rd., Southboro Relation, if any wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Agent
(Official Designation)

Nov. 28, 1944
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 28 1944
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1920, to Nov 28, 1944

I last saw him alive on Nov 27, 1944, death is said to have occurred on the date stated above, at 2.30 A M.

Immediate cause of death: Arteriosclerosis Coronary — Duration IMPORTANT 3 years

Due to Obstruction coronary thrombosis — 3 hrs

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none Date of

Of autopsy none

What test confirmed diagnosis Physical signs

IMPORTANT Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Roland B Marston M. D.
(Address) Westboro Date Nov 28 1944

21 Rural Southboro
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL November 28, 1944

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15 Cottage Ave., Marlboro

Received and filed Nov 30 1944
(Registrar)

A TRUE COPY ATTEST:

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m (g)-1-41-4067

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Fay School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas Slattery
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR) .....

(a) Residence. No. Main St. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community yrs. 3 mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 62 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Laborer

10 Industry or Business: Fay School

11 Social Security No. 017-05-7608

12 BIRTHPLACE (City) (State or country): Southboro Mass

PARENTS

13 NAME OF FATHER: Jeremiah Slattery

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Norah Hanley

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address): Mrs Nora Myers (Sister) 87 Church St. Marlboro (Relation, if any)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Telfer
(Signature of Agent or Board of Health or other)

Burial Agent Dec 1 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: November 30 1944
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....
Date of occurrence ..... 19 .....
Where did Injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
Nature of Injury .....
While at work? ..... Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Walter F Mahoney, M. D.
(Address) Westboro Date Nov 30 1944

22 Immaculate Conception Malden
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec 3 1944

23 NAME OF FUNERAL DIRECTOR John J Brown
ADDRESS 78 W Main St. Marlboro

Received and filed ..... 19 .....
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

MIDDLESEX (County)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MARLBOROUGH (City or town making return)

COPY OF CERTIFICATE OF DEATH

Registered No. .....

1 PLACE OF DEATH: (County) MARLBOROUGH (City or Town) No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John E. Barker (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. East Main St. St. Southboro Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or ~~institution~~ 3 dys (Before death) (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	white	wid

5a If married, widowed, or divorced
HUSBAND of Mary E. Temple (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 85 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: retired

10 Industry or Business: railroad worker

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Leominster Mass

PARENTS

13 NAME OF FATHER John A. Barker

14 BIRTHPLACE OF FATHER (City) (State or country) Leominster Mass

15 MAIDEN NAME OF MOTHER Sophia Barker

16 BIRTHPLACE OF MOTHER (City) (State or country) Granby Mass

17 Informant (Address) Grace F. Barker E. Main St. Southboro (Relationship, if any) dau

A TRUE COPY.
ATTEST: F. J. Gatraud
(Registrar of city or town where death occurred)
DATE FILED Dec 13 1944 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec (Month) 10 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 6, 1944 to Dec 9, 1944
I last saw him alive on Dec 9 1944 death is said to have occurred on the date stated above, at 5.55 A.M.

Immediate cause of death	Duration
appendicitis (acute)	4 dys
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) arterio sclerosis	
Major findings: Of operations acute gangrenous & ruptured appendix Date of 12-7-44	
Of autopsy	
What test confirmed diagnosis? oper	

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Clyde H. Merrill, M. D.
(Address) Marlborough Date 12-11, 1944

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Southboro (Cemetery) (City or Town)
DATE OF BURIAL Dec 13 1944 19

22 NAME OF FUNERAL DIRECTOR Wm. M. Tighe
ADDRESS .....

Received and filed 19
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY

DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry L. Gilman (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Southville Road St. Southborough (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Hospital (Before death) (Specify whether) years months 1 days. In this community 15 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Lilla J. Harrington (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 71 Years 8 Months 17 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Mechanical Engineer

10 Industry or Business: Mechanics

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Hanover Maine

PARENTS

13 NAME OF FATHER Charles L. Gilman

14 BIRTHPLACE OF FATHER (City) (State or country) Unknown

15 MAIDEN NAME OF MOTHER Mary Smith

16 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

17 Informant Lilla H. Gilman (Address) Southboro, Mass. (Relation, if any) (Wife)

A TRUE COPY. ATTEST: Wm. J. Walsh (Registrar of city or town where death occurred)

DATE FILED December 21, 1944

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December (Month) 18, (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from March 1, 1944, to December 18 1944

I last saw him alive on Dec. 17, 1944, death is said to have occurred on the date stated above, at 8:25 a.m.

	Duration
Immediate cause of death: Acute left ventricullar failure	24hrs.
secondary cerebral anoxemia	
Due to Chronic hypertensive Heart disease	2yrs.+
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ..... Date of .....

Of autopsy above

What test confirmed diagnosis? autopsy

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Hugh Folsom, M. D.

(Address) Framingham Date 12/18 1944

21 PLACE OF BURIAL, CREMATION OR REMOVAL Edgell Grove, Fram. (Cemetery) (City or Town)

DATE OF BURIAL December 21, 1944

22 NAME OF FUNERAL DIRECTOR Vernon E. Morrill

ADDRESS 15 Church St., Hopkinton

Received and filed ..... 19.....

(Registrar of City or Town where deceased resided)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) _____

Registrar's No. _____

1 PLACE OF DEATH: Worcester (County) / Fayrille (City or Town) / No. Turnpike Rd St. { (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Josephine E Scanlan Hadley (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) _____

(a) Residence. No. Turnpike Rd St. _____ (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution _____ years _____ months _____ days. (Before death) (Specify whether) In this community 33 yrs. _____ mos. _____ days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of _____
(Give maiden name of wife in full)
(or) WIFE of Osgood F Hadley
(Husband's name in full)

6 Age of husband or wife if alive _____ years

7 IF STILLBORN, enter that fact here.

8 AGE 89 Years ____ Months ____ Days | If less than 1 day ____ Hours ____ Minutes

9 Usual Occupation: At Home

10 Industry or Business: _____

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Lawrence Mass

PARENTS

13 NAME OF FATHER M Scanlan

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Lucretia Cooley

16 BIRTHPLACE OF MOTHER (City) (State or country) Maine

17 Informant (Address) Paul Hadley Turnpike Rd Fayrille Relation, if any (Son)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agent Dec 28, 1944
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December (Month) 27 (Day) 1944 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1944, to Dec 27, 1944

I last saw her alive on Dec 27, 1944 death is said to have occurred on the date stated above, at 8 20 P. M.

Immediate cause of death Cardiac Decompensation & Bronchopneumonia.

Duration IMPORTANT

Due to Senility

Due to Arteriosclerosis.

Other conditions Decubitus Ulcer, Old Cerebral Thrombosis
(Include pregnancy within 3 months of death)

IMPORTANT

Major findings:
Of operations _____ Date of _____
Of autopsy _____
What test confirmed diagnosis? _____

Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Jean C. Avery, M. D.
(Address) 154 Union Ave Framingham Date Dec 27 1944

21 Rural Southboro mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec 30 1944

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro mass

Received and filed _____ 19____

(Registrar)

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. .....

1 PLACE OF DEATH
Middlesex (County)
Framingham (City or Town)
No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Catherine C. Watkins (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Richards Road St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years months days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of John Watkins (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Cincinnati Ohio

PARENTS

13 NAME OF FATHER: Thomas Walsh

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: (Unknown) Foster

16 BIRTHPLACE OF MOTHER (City) (State or country): Columbus Ohio

17 Informant (Address): David F. Watkins son Southboro, Mass. (Relation, if any .....)

A TRUE COPY.
ATTEST: Wm. J. Walsh
(Registrar of city or town where death occurred)
DATE FILED January 5, 1945

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: January 1, 1945 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from December 25, 1944 to January 1, 1945
I last saw her alive on January 1, 1945 death is said to have occurred on the date stated above, at 5:10 P. m.

Immediate cause of death	Duration
Strangulated ventral hernia	6 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Uremia	4 days

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? Operation

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Eugene A. Gaston, M. D.
(Address) Framingham Date 1/2/ 1945

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Grove Cem. (Cemetery) Southboro (City or Town)
DATE OF BURIAL January 4, 1945

22 NAME OF FUNERAL DIRECTOR: T. F. Callanan & Son
ADDRESS: Hopkinton, Mass.

Received and filed ..... 19.....
(Registrar of City or Town where deceased resided)

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50m (g)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: (County) ..... (City or Town) Southboro No. Turnpike Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary A Waldron (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Turnpike Rd St. ..... (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... (Before death) 1 years (Specify whether) months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of John J Waldron (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 55 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: at home

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Ireland

PARENTS

13 NAME OF FATHER John J Cauley

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Sarah Johnson

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Mrs Mary Gagne Relation, if any daughter

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

James F. Feeley (Agent.) (Signature of Agent of Board of Health or other)

(Agent.) (Official Designation)

January 8-1945 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: January (Month) 8 (Day) 1945 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary occlusion
Generalized Arteriosclerosis

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19.....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? ..... Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date Jan 8 1945

22 St John Worcester
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Jan 9 1945

23 NAME OF FUNERAL DIRECTOR C H Talley

ADDRESS 41 Irving Worcester Mass.

Received and filed Jan. 25 1945

Minnie F. McBrearty (Registrar)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

200m-10-'39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH Worcester (County)
Southborough (City or Town)
No. Turnpike Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Minnie Blanche Fay nee O'Leary (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Turnpike Rd. St. (Usual place of abode) (If nonresident, give city or town and state)
Length of stay: In hospital or institution .... years months days. In this community 44 yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married
5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Louis Winfred Fay (Husband's name in full)
6 Age of husband or wife if alive 72 years
7 IF STILLBORN, enter that fact here.
8 AGE 65 Years 13 Months 1 Days. If less than 1 day Hours Minutes
9 Usual Occupation: house wife
10 Industry or Business: home
11 Social Security No.
12 BIRTHPLACE (City) near Minas, Kings County (State or country) Nova Scotia

PARENTS
13 NAME OF FATHER Arthur James O'Leary
14 BIRTHPLACE OF FATHER (City) -?- (State or country) Nova Scotia
15 MAIDEN NAME OF MOTHER Adelaide Harrington
16 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia

17 Informant Louis W. Fay Relation, if any (Husband)
(Address) Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
James F. Telfer
(Signature of Agent of Board of Health or other)
Burial Agent (Official Designation)
Jan. 17 1945 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January (Month) 14 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 1, 1942 to Jan 14, 1945
I last saw her alive on Jan 13, 1945, death is said to have occurred on the date stated above, at 1.20 a.m.

	Duration
Immediate cause of death: Myocarditis chronic	-?-
Due to: Arterio sclerosis chronic	-?-
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN: Underline the cause to which death should be charged statistically.

Major findings:
Of operations: none
Date of
Of autopsy: no
What test confirmed diagnosis: Physical exam.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Roland S. Marston, M. D.
(Address) Central Westboro Date Jan 14 1945

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Jan 17 1945

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed Jan 25 1945
Marguerite F. McDonald (Registrar)

A TRUE COPY ATTEST:

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No. _____

1 PLACE OF DEATH: Worcester (County) / Southboro (City or Town)

No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles La Forest Fairbanks (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) _____

(a) Residence. No. Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution _____ years _____ months _____ days. (Before death) (Specify whether) In this community 83 yrs. 2 mos. 1 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Marie Bouthillet (Give maiden name of wife in full)

(or) WIFE of _____ (Husband's name in full)

6 Age of husband or wife if alive 81 years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 2 Months 1 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired town clerk

10 Industry or Business: _____

11 Social Security No. None

12 BIRTHPLACE (City) Southboro (State or country) Mass

PARENTS

13 NAME OF FATHER Joseph Fairbanks

14 BIRTHPLACE OF FATHER (City) Bellingham (State or country) Mass.

15 MAIDEN NAME OF MOTHER Betsy Thompson

16 BIRTHPLACE OF MOTHER (City) Stoddard (State or country) New Hampshire

17 Informant Mrs Marie Fairbanks (Relation, if any) Wife

(Address) Main St, Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Peeler
(Signature of Agent of Board of Health or other)

Burial Permit Feb. 3. 1945
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb (Month) 8 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1945, to Feb 8, 1945

I last saw him alive on Feb 8, 1945, death is said to have occurred on the date stated above, at 8 50 P.M.

	Duration IMPORTANT
Immediate cause of death: Circulatory failure	2 days
Due to: General arteriosclerosis	5 years
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

IMPORTANT

Physician Underline the cause to which death should be charged statistically.

Major findings: Of operations _____ Date of _____

Of autopsy _____

What test confirmed diagnosis? _____

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Hugh Folsom, M. D.

(Address) Framingham Date Feb 10 1945

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Feb 11, 1945 19

22 NAME OF FUNERAL DIRECTOR Gunner L. Gage

ADDRESS 156 Boulevard Ave., Marlboro, Mass.

Received and filed Feb 23 19 45

Registrar

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. .....

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town); No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Timothy F. McAvoy (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. ..... St. Fay School Southborough Mass (If nonresident, give city or town and State)

(Usual place of abode) Hosp 6 dys

Length of stay: In hospital or institution (Before death) ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced HUSBAND of Margaret Fee (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 60 years

7 IF STILLBORN, enter that fact here.

8 AGE 64 Years 9 Months 19 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: attendant private school

10 Industry or Business: .....

11 Social Security No. 012-20-7005

12 BIRTHPLACE (City) (State or country) Milford Mass

PARENTS

13 NAME OF FATHER Henry McAvoy

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Mary Ann Rogers

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Mrs Margaret McAvoy (Relation wife) Framingham Teachers College

A TRUE COPY.

ATTEST: F. J. Bertrand (Registrar of city or town where death occurred)

DATE FILED Mar 1 1945 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb 28 1945 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from 2-21- 19 45, to Feb 28 19 45

I last saw him alive on Feb 28 1945 death is said to have occurred on the date stated above, at ..... m.

Immediate cause of death ..... Duration

intestinal obstruction .....

of large intestine due to .....

Due to band of adhesions .....

Due to ....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations intestinal obstruction

Date of 2-27-45

Of autopsy .....

What test confirmed diagnosis? operation

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) William J. Delaney, M. D.

(Address) 186 Main St. City Date 2-28-45

21 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Milford Mass

DATE OF BURIAL Mar 3 1945 (Cemetery) (City or Town)

22 NAME OF FUNERAL DIRECTOR Joseph F. Edwards

ADDRESS Milford Mass

Received and filed Mar 5 1945

(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

25M-(f)-11-42 10746

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 62

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Sullivan, John F. (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Newton St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) 1 years 2 months 7 days. In this community 80 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
male	white	widowed

5a If married, widowed, or divorced HUSBAND of Julia Murphy (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ____ years

7 IF STILLBORN, enter that fact here.

8 AGE 81 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Laborer

10 Industry or Business: Coal Company

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Southboro Mass.

PARENTS

13 NAME OF FATHER: John Sullivan

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Mary Sheehan

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address) Westborough State Hospital records (Relation, if any)

A TRUE COPY. ATTEST: Annie A. Dunne
(Registrar of city or town where death occurred)

DATE FILED April 11, 1945

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 9, (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1944, to April 9, 1945

I last saw him alive on April 8, 1945, death is said to have occurred on the date stated above, at 4:50 a.m.

	Duration
Immediate cause of death: Broncho Pneumonia	6 days
Due to: Pulmonary Tuberculosis	unk.
Due to: rt. upper lobe	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations ____ Date of ____

Of autopsy April 9, 1945

What test confirmed diagnosis? Clinical, Lab. and P.M.

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Herman Rickless, M. D.

(Address) Westboro, Mass. Date 4/9 1945

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural (Cemetery) Southboro (City or Town)

DATE OF BURIAL April 11, 1945

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Marlboro, Mass.

Received and filed 19

(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-'39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

(City or town making return) ..... Registered No. .....

1 PLACE OF DEATH: Bristol (County) — Dartmouth (City or Town) — No. Hixville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Luella E. (Greene) Bassett (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Gilmore Road St. Southboro, Mass. (If nonresident, give city or town and state)
(Usual place of abode)
Length of stay: In hospital or institution ..... years ..... months ..... days. In this community yrs. 6 mos. ..... days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Isaac Franklin Bassett
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 69 Years 11 Months — Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: housekeeper

10 Industry or Business: for herself

11 Social Security No. 028-09-4250

12 BIRTHPLACE (City) (State or country) Dartmouth, Mass.

PARENTS

13 NAME OF FATHER David Greene

14 BIRTHPLACE OF FATHER (City) (State or country) Dartmouth, Mass.

15 MAIDEN NAME OF MOTHER Mary E. Chase

16 BIRTHPLACE OF MOTHER (City) (State or country) Westport, Mass.

17 Informant Mrs. W.A. Maynard, Jr. Relation, if any daughter
(Address) 67 Brookside Ave., Newtonville

A TRUE COPY.
ATTEST: Thomas B. Hume
(Registrar of city or town where death occurred)

DATE FILED 4-23- 1945

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 17, (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 5, 1943, to Apr. 17, 1945
I last saw her alive on Apr. 12, 1945, death is said to have occurred on the date stated above, at 8 A. m.

	Duration
Immediate cause of death: Cerebral hemorrhage	2 days
Due to Arteriosclerosis	5 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? usual

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) Cecil Smith M. D.
(Address) New Bedford Date 4/18 1945

21 PLACE OF BURIAL, CREMATION OR REMOVAL Maple Grove, Westport
(Cemetery) (City or Town)
DATE OF BURIAL April 20 1945

22 NAME OF FUNERAL DIRECTOR H. W. Brightman
ADDRESS N. Westport, Mass.

Received and filed May 4 1945
Maynard E. McManus
(Registrar of City or Town where deceased resided)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m (d)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Southboro (County) — ~~Southborough~~ — Fayville (City or Town) — No. Central Street St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank Parodi
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Oregon Road St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community 10 yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of .....
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 63 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired-Printer

10 Industry or Business: .....

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

13 NAME OF FATHER Joseph Parodi

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER Louise Casale

16 BIRTHPLACE OF MOTHER (City) (State or country) Italy

17 Informant Marie Guinasso (Relation, if any Sister)
(Address) Cental St., Fayville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul P. Henderson
(Signature of Agent of Board of Health, or other)

Chmn Bd of Health 5/3/45
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May 1 1945
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 14, 1945, to April 30, 1945
I last saw h... alive on April 30, 1945, death is said to have occurred on the date stated above, at 6.15 A m.

	Duration
Immediate cause of death IMPORTANT: Chronic Myocarditis	
Due to	
Due to	
Other conditions. (Include pregnancy within 3 months of death) Ascites, Uremia	5 days

IMPORTANT

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Joseph Tommasula, M. D.
(Address) 100 Washington St. Date May 5, 1945

21 Rural Cemetery, Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 4, 1945

22 NAME OF FUNERAL DIRECTOR Michael J. Gonella
ADDRESS 10 No. Benett St., Boston, Mass.

Received and filed May 15 1945
Margaret T. McDermott
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK -- THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

25M-(f)-11-42 10746

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 86

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town); No. Houghton Nursing Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret A. Woodard (Taylor) (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) no

(a) Residence. No. Southville Road (Usual place of abode) or Southville, Mass. (If nonresident, give city or town and State)

Length of stay: In hospital or institution nursing home (Before death) (Specify whether) years - months 7 days. In this community 34 yrs. - mos. - days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George H. Woodard (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive 66 years

7 IF STILLBORN, enter that fact here.

8 AGE 67 Years 2 Months 8 Days | If less than 1 day Hours Minutes

9 Usual Occupation: housewife

10 Industry or Business: own home

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Aberdeen Scotland

PARENTS

13 NAME OF FATHER: David Taylor

14 BIRTHPLACE OF FATHER (City) (State or country): - Scotland

15 MAIDEN NAME OF MOTHER: cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country): - Scotland

17 Informant Geo. H. Woodard (Address) Southville. Relation, if any (husband)

A TRUE COPY. ATTEST: Annie A. Dunne (Registrar of city or town where death occurred)

DATE FILED May 18, 1945

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May (Month) 14, (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan., 1945, to May, 1945

I last saw her alive on May 14, 1945 death is said to have occurred on the date stated above, at 4 p. m.

Immediate cause of death — Duration

acute nephritis — 1 month

Due to: chr. myocarditis — 10 yrs.

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Date of

Of autopsy

What test confirmed diagnosis? stethescope

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F. Mahoney, M. D.

(Address) Westboro Date May 14 1945

21 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Pleasant, Arlington (Cemetery) (City or Town)

DATE OF BURIAL May 17, 1945

22 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed June 14 1945

(Registrar of City or Town where deceased resided)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Winchester St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Margaret Lydia (Reynolds) Misener
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Winchester St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution — 6 — years months days. In this community 42 yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles O. Misener
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years 2 Months 14 Days | If less than 1 day Hours Minutes

9 Usual Occupation: At home

10 Industry or Business: At home

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Lunenburg Nova Scotia

PARENTS

13 NAME OF FATHER Lewis Reynolds

14 BIRTHPLACE OF FATHER (City) (State or country) Nova Scotia

15 MAIDEN NAME OF MOTHER Elizabeth A. Smith

16 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia

17 Informant (Address) Mrs Herbert McKenzie Plymouth St. Marlboro Relation, if any (Daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agent June 1, 1945
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May 30 1945
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 3, 1944, to May 30, 1945
I last saw her alive on May 29, 1945, death is said to have occurred on the date stated above, at 2.15 A M.

Immediate cause of death: Myocardial disease — Duration IMPORTANT: 3 years

Due to: Arterio sclerosis — 2

Due to:

Other conditions: none
(Include pregnancy within 3 months of death)

Major findings: Of operations: none — Date of:

Of autopsy: no — What test confirmed diagnosis? Clinic course / Physical signs

IMPORTANT Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Roland A. Hamlin, M. D.
(Address) 9 Central Sq Westboro Date May 30 1945

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL June 2, 1945

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15 Cutting Ave., Marlboro

Received and filed June 6 1945
(Registrar)

A TRUE COPY ATTEST:

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

200m-10-39. No. 8427-d

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No.

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southborough; No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Flora Augusta Stone nee Jordan (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Southville Road St. Southville (If nonresident, give city or town and state) (Usual place of abode)

Length of stay: In hospital or institution no (Specify whether) years months days. In this community 9 yrs. 3 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W Stone (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive 67 years

7 IF STILLBORN, enter that fact here.

8 AGE 72 Years 3 Months 26 Days | If less than 1 day Hours Minutes

9 Usual Occupation: home maker

10 Industry or Business: home

11 Social Security No.

12 BIRTHPLACE (City) (State or country): Holden Mass

PARENTS

13 NAME OF FATHER: Gloriano E Jordan

14 BIRTHPLACE OF FATHER (City) (State or country): Mass

15 MAIDEN NAME OF MOTHER: Mary

16 BIRTHPLACE OF MOTHER (City) (State or country):

17 Informant (Address): George W Stone Southville Mass Relation, if any: husband

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Feeley (Signature of Agent of Board of Health or other)
Burial Agent (Official Designation) June 9, 1945 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 8 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1933, to June 8, 1945

I last saw h.. alive on June 7, 1945, death is said to have occurred on the date stated above, at 3.15 p.m.

	Duration
Immediate cause of death: Myocarditis Chronic	-3-
Due to Arterio sclerosis Chronic	-2-
Due to	
Other conditions: none (Include pregnancy within 3 months of death)	

Major findings:
Of operations: none
Date of
Of autopsy: none
What test confirmed diagnosis: Physical exam

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Roland L Thurston, M. D.
(Address) 9 Central Worcester Date June 8 1945

21 Wildwood Cemetery Ashland Mass. Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL June 10, 1945

22 NAME OF FUNERAL DIRECTOR Vernon E Morrill
ADDRESS 15 Church St Hopkinton Mass

Received and filed June 11 1945
A TRUE COPY ATTEST: (Registrar)

FORM R-301 A

N.B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. Bates Rest Home, Cataquama Rd, Southboro, St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN-IMPORTANT

2 FULL NAME Minnie F. Robbins
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 28 Eden St., Framingham, Mass. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) ..... years ..... months ..... days. In this community ~~45~~ yrs. 6 mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Widowed

5a If married, widowed or divorced HUSBAND of Edwin J. Robbins
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 76 Years 4 Months 8 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Home

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or Country) Suffield, Conn.

PARENTS

13 NAME OF FATHER Samuel Bliss

14 BIRTHPLACE OF FATHER (City) (State or Country) Conn.

15 MAIDEN NAME OF MOTHER Marion Howe

16 BIRTHPLACE OF MOTHER (City) (State or Country) Conn.

17 Informant Mrs. Olive Cook (Relation, if any)
(Address) 90 Western Ave., Sherborn, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

James F. Leeper
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) June 11, 1945 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June (Month) 11 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 10, 1945, to June 9, 1945

I last saw h[illegible] alive on June 9, 1945, death is said to have occurred on the date stated above, at ~3:30 m.

Immediate cause of death Chronic Myocarditis, sudden death, — Duration IMPORTANT ?

Due to Malignant Hypertension ?

Due to .....

Other conditions Nephritis — ?
(Include pregnancy within 3 months of death)

IMPORTANT

Major findings: Of operations .....

Date of .....

Of autopsy .....

What test confirmed diagnosis? .....

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Joseph T. Cunningham M. D.

(Address) Main St. Natick Date June 11 1945

21 Place of Burial, Cremation or Removal Glenwood Cemetery, Natick, Mass.
(City or Town)

DATE OF BURIAL June 13, 1945

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson

ADDRESS Framingham, Mass.

Received and Filed June 14 1945

(Registrar)

ORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m(j)-1-44-13634

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — South Framingham (City or Town) — No. Malindy Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

2 FULL NAME Gene Brown
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Nobscot, Mass. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... (Before death) 2 years months days. (Specify whether) In this community ~~60~~ yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 64 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired (cripple)

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Stow, Mass.

PARENTS

13 NAME OF FATHER Isreal Brown

14 BIRTHPLACE OF FATHER (City) (State or country) Unknown

15 MAIDEN NAME OF MOTHER (maiden name unknown) Lucy E. Brown

16 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

17 Informant (Address) Welfare Dept. Framingham Framingham, Mass. Relation, if any

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tefft
(Signature of Agent of Board of Health or other)

Burial Agent June 15. 1945
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June (Month) 14 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 11, 1945, to June 14, 1945

I last saw h... alive on June 13, 1945, death is said to have occurred on the date stated above, at 6:15 A m.

	Duration
Immediate cause of death Progressive Muscular Dystrophy	IMPORTANT
Due to Unknown	since 1890
Due to	
Other conditions (Include pregnancy within 3 months of death)	IMPORTANT
Major findings: Of operations — Date of	Physician Underline the cause to which death should be charged statistically.
Of autopsy —	
What test confirmed diagnosis? Clinical	

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Spencer Cason, M. D.
(Address) Weston Mass. Date June 17 1945

21 Place of Burial, Cremation or Removal: Forest Vale Hudson, Mass. (City or Town)
DATE OF BURIAL June 16, 1945

22 NAME OF FUNERAL DIRECTOR Frederick A. Erickson
ADDRESS Framingham, Mass.

Received and filed June 26 1945
Maynard F. Woodward
(Registrar)

FORM R-301 A

N. B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southboro, Mass. (City or Town)

No. Turnpike Rd., Fayville, Mass. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Jane Bunce
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Turnpike Rd., Fayville, Mass. St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) ..... years ..... months ..... days. In this community 3 yrs. ..... mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Married

5a If married, widowed or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Henry J. Bunce
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 67 Years 7 Months 30 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Home

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or Country) West Fairlee, Vt.

PARENTS

13 NAME OF FATHER John Rule

14 BIRTHPLACE OF FATHER (City) Cornwall, England
(State or Country)

15 MAIDEN NAME OF MOTHER Mary Jane James

16 BIRTHPLACE OF MOTHER (City) Cornwall, England
(State or Country)

17 Informant (Address) Mrs. Gertrude Lewis (Daughter) (Relation, if any)
Turnpike Rd., Fayville, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tucker
(Signature of Agent of Board of Health or other)

Burial Agent. June 22, 1945
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June (Month) 20 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1944, to June 20, 1945

I last saw h e alive on June 20, 1945, death is said to have occurred on the date stated above, at 3:15 P m.

Immediate cause of death	Duration
Heart Block & Stokes Adams Syndrome	2 mos
Due to Hypertensive + A-S Heart Disease	2 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	

IMPORTANT

Major findings: Of operations ..... Date of .....

Of autopsy .....

What test confirmed diagnosis? .....

IMPORTANT
Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Hugh Tolson, M. D.
(Address) 198 Middle Ave Date June 21 1945

21 Place of Burial Village Cemetery, Tunbridge, Vt. (City or Town)
DATE OF BURIAL June 23, 1945 19

22 NAME OF FUNERAL DIRECTOR Frederick A. Erickson
ADDRESS Framingham, Mass.

Received and Filed June 28 1945
Maynie M. Winsor
(Registrar)

ORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(e)-3-43-11574

NOV 20 1860

PLACE OF DEATH
1 (County) Worcester
(City or Town) Southboro

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registrar's No. _____

No. Boston Road cor "A" St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Patrick Coleman (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) _____

(a) Residence. No. Boston Road cor A St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution No years months days. In this community / yrs. — mos. — days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Widower

5a If married, widowed, or divorced
HUSBAND of Julia A. Lucey (Give maiden name of wife in full)
(or) WIFE of _____ (Husband's name in full)

6 Age of husband or wife if alive deceased years

7 IF STILLBORN, enter that fact here.

8 AGE 84 Years 7 Months 7 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired Sgt. Police

10 Industry or Business: Police Watertown

11 Social Security No. No

12 BIRTHPLACE (City) (State or country) REXVILLE New York

PARENTS

13 NAME OF FATHER William Coleman

14 BIRTHPLACE OF FATHER (City) (State or country) IRELAND

15 MAIDEN NAME OF MOTHER Julia Driscoll

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) George W. Coleman Boston Post Rd. Southboro Relation, if any Son

was filed with me BEFORE the burial or transit permit was issued:
I HEREBY CERTIFY that a satisfactory standard certificate of death

James F. Tiefer
(Signature of Agent of Board of Health or other)

Burial Agent
(Official Designation)

June 27 1945
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June (Month) 27 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 26, 1945, to June 27, 1945
I last saw him alive on June 27, 1945, death is said to have occurred on the date stated above, at 4:20 P.M.

Immediate cause of death — Duration IMPORTANT
Coronary occlusion-c. _____
Left ventricular failure 18 hrs.
Due to Coronary arteriosclerosis 4yrs

Due to _____

Other conditions (Include pregnancy within 3 months of death) IMPORTANT

Major findings: Of operations _____ Date of _____
Of autopsy _____
What test confirmed diagnosis? Ecg.

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Hugh Folsom, M. D.
(Address) Framingham Date June 27 1945

21 ST. PATRICKS Watertown
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL June 30 1945

22 NAME OF FUNERAL DIRECTOR Wm P. Gallagher
ADDRESS 3 Green St. Watertown

Received and filed June 28 1945
Minnie T. McDonald
(Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m(j)-1-44-13634

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County) — Southbridge (City or Town) — No. Lake Chaubunagungamaug Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Fred E. Baker (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Lake Chaubunagungamaug Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 6 yrs. ..... mos. ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of Gertrude Hodgson (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 63 years

7 IF STILLBORN, enter that fact here.

8 AGE 62 Years 7 Months 0 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Rest Home

10 Industry or Business: Owner

11 Social Security No. .....

12 BIRTHPLACE (City) Westboro (State or country) Mass

PARENTS

13 NAME OF FATHER Marshall T. Baker

14 BIRTHPLACE OF FATHER (City) Grafton (State or country) Mass

15 MAIDEN NAME OF MOTHER Martha M. Woods

16 BIRTHPLACE OF MOTHER (City) Dudley (State or country) Mass

17 Informant Mrs Fred E Baker (Address) Lake Chaubunagungamaug Rd Southbridge Mass (Relation, if any)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Samuel Seller (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) July 4 1945 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 2 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 29, 1941, to July 2, 1945

last saw h[illegible] alive on July 2, 1945, death is said to have occurred on the date stated above, at 2.20 P. m.

Immediate cause of death	Duration
Hypostatic Congestion	3 days
Due to Arteriosclerosis	4 yrs
Due to	
Other conditions (include pregnancy within 3 months of death)	

IMPORTANT

Major findings: Of operations none Date of .....
Of autopsy none
What test confirmed diagnosis? Physical exam

IMPORTANT

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Ronald J Bruchac, M. D.
(Address) Westboro Date July 5 1945

21 Pine Grove Cemetery Westboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 5 1945

22 NAME OF FUNERAL DIRECTOR Irving W. Harper
ADDRESS 62 W. Main St. Westboro Mass.

Received and filed ..... 19 .....
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

WORCESTER
(City or town making return)

Registered No. .....

1 PLACE OF DEATH

WORCESTER (County)

WORCESTER (City or Town)

No. Memorial Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME --- Coleman (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. Boston Road St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution hospital years months days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here. stillborn

8 AGE .....Years .....Months .....Days | If less than 1 day .....Hours .....Minutes

9 Usual Occupation: .....

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Worcester

PARENTS

13 NAME OF FATHER George W

14 BIRTHPLACE OF FATHER (City) (State or country) Watertown

15 MAIDEN NAME OF MOTHER Sophie Stankievtz

16 BIRTHPLACE OF MOTHER (City) (State or country) Berlin Conn

17 Informant Father (Relation, if any .....)
(Address) Southboro

A TRUE COPY.
ATTEST: Malcolm E. McLaughlin
(Registrar of city or town where death occurred)
DATE FILED July 25, 1945 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 22, 1945
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from ---, 19..., to ---, 19...
I last saw h... alive on ---, 19..., death is said to have occurred on the date stated above, at ---m.

Immediate cause of death ..... Duration .....
Stillbirth .....
Due to Prematurity .....
Due to ....
Other conditions ....
(Include pregnancy within 3 months of death) .....
Major findings: .....
Of operations ..... Date of .....
Of autopsy ....
What test confirmed diagnosis? .....

Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? —
If so, specify .....
(Signed) Joseph P O'Connor, M. D.
(Address) Worcester Date ---19

21 PLACE OF BURIAL, CREMATION OR REMOVAL St Patrick's Watertown
(Cemetery) (City or Town)
DATE OF BURIAL July 24, 1945 19

22 NAME OF FUNERAL DIRECTOR John P Gallagher
ADDRESS Watertown

Received and filed 19
(Registrar of City or Town where deceased resided)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m (g)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. Metropolitan Reservoir St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Decker, Harold C.
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. 251 Mill St. St. Newtonville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution..... years months days. In this community 19 yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 64 Years 3 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Grocery salesman

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) East Orange
(State or country) New Jersey

PARENTS

13 NAME OF FATHER: Caton L. Decker

14 BIRTHPLACE OF FATHER (City) Wellsburg
(State or country) New York

15 MAIDEN NAME OF MOTHER: Alice Hoyt

16 BIRTHPLACE OF MOTHER (City) Norwalk
(State or country) Connecticut

17 Informant (Address) Westborough State Hospital Records (Relation, if any) .....

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Samuel F. Decker
(Signature of Agent of Board of Health or other)
Agent
(Official Designation)
August 6, 1945
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 26 (Day) 1945 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

asphyxiation by drowning
Suicide

20 Accident, suicide, or homicide (specify) Suicide
Date of occurrence July 26 1945
Where did Injury occur? Southborough Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Reservoir - (Metropolitan)
(Specify type of place)
Manner of Injury Tied stone about his waist and entered the water
Nature of Injury Drowning
While at work? no Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Walter F. Cushman, M. D.
(Address) Westboro, Mass. Date Aug. 6 1945

22 Burial Worcester
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Aug. 6 1945

23 NAME OF FUNERAL DIRECTOR Irving A. Hooper
ADDRESS 62 Austin St Worcester

Received and filed Aug 20 1945
Irving F. Del Bernard.
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No.

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Middle St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Philip P. J. Neary
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Middle St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 67 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Real Estate & Insurance Broker

10 Industry or Business: Real Estate & Insurance

11 Social Security No.

12 BIRTHPLACE (City) Southboro (State or country) Mass

PARENTS

13 NAME OF FATHER: John Neary

14 BIRTHPLACE OF FATHER (City) Roscommon (State or country) Ireland

15 MAIDEN NAME OF MOTHER: Delia Mann

16 BIRTHPLACE OF MOTHER (City) Roscommon (State or country) Ireland

17 Informant: D. J. F. Neary (Relation, if any) Brother
(Address) Middle St. Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tufts
(Signature of Agent of Board of Health or other)

Burial Agent
(Official Designation)

July 29, 1945
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: July (Month) 26 (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 10, 1944, to July 26, 1945
I last saw h alive on , 19 , death is said to have occurred on the date stated above, at 7 PM.

Immediate cause of death: Myocarditis — Duration IMPORTANT: 2 yrs.

Due to: Arterio sclerosis — 2 yrs.

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: none — Date of:

Of autopsy: — What test confirmed diagnosis? Physical exam.

IMPORTANT — Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Edward F. Ryan, M. D.
(Address) Worcester Mass Date 7/27 1945

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 29, 1945

22 NAME OF FUNERAL DIRECTOR John J. Brown
ADDRESS 96 West Main St. Marlboro Mass

Received and filed 19

(Registrar)

A TRUE COPY ATTEST:

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m (g)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH

(County) .....

(City or Town) Southboro. Mass.

No. Middles Road. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hugh Heckle (Hugh Heckle)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Middle$ Road St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution home years months days. In this community 12 yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced
HUSBAND of Lucy Owen
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years 5 Months 11 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Carpenter

10 Industry or Business: retired

11 Social Security No. .....

12 BIRTHPLACE (City) Liverpool
(State or country) England

PARENTS

13 NAME OF FATHER Richard Heckle

14 BIRTHPLACE OF FATHER (City) Liverpool
(State or country) England

15 MAIDEN NAME OF MOTHER unobtainable

16 BIRTHPLACE OF MOTHER (City) "
(State or country)

17 Informant Mrs. Lucy Heckle (Relationship, if any) wife
(Address) Southboro. Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Peters
(Signature of Agent of Board of Health or other)

Burial Agent Aug. 21. 1945
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH August 20 1945
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....
Date of occurrence 19
Where did injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
Nature of Injury .....
While at work? ..... Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Walter F. Mahoney, M. D.
(Address) Westborough Date Aug 20 1945

22 Mt. Auburn, Hopkinton. Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL August 22. 1945. 19

23 NAME OF FUNERAL DIRECTOR John L. Norton Sr.
ADDRESS Framingham. Mass.

Received and filed 19
(Registrar)

COPY OF CERTIFICATE OF DEATH

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
Bureau of the Census

STATE OF NEW HAMPSHIRE

Town or City Clerk's No. 999

FULL NAME Mary Cassinari Boselli

1. PLACE OF DEATH:
(a) County Hillsboro
(b) City or town Manchester
(c) Name of hospital or institution: At Home
(If not in hospital or institution write street number or location)
(d) Length of stay:
In hospital or institution
(Specify whether years, months or days)
In this community
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State NH
(b) County Hillsboro
(c) City or town Manchester
(d) Street No. 393 Porter
(If rural, give location)
(e) If foreign born, how long in U.S.A.? ..... years

3. (a) x x x x x x x x x x x x x x x x x x x x
(b) If veteran, name war
(c) Social Security No.

4. Sex	5. Color—race	6. (a) Single, wid., mar., div.
F	W	Widowed

6. (b) Name of husband or wife: ----------
(Full name—Maiden name, if wife)
6. (c) Age of husband or wife, if alive ..... years
7. Birth date of deceased 1879
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
66	--	--	....hrs. ....min.

9. Birthplace Italy
(City, Town, or County) (State or Foreign Country)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name ----------
13. Birthplace
(City, Town, or County) (State or Foreign Country)

MOTHER
14. Maiden name ----------
15. Birthplace ----------
(City, Town, or County) (State or Foreign Country)

16. (a) Informant's own signature Chester J. Boselli
(b) Address 393 Porter St.
17. (a) Burial
(Burial, Cremation, or Removal)
(b) Date thereof 10-31-45
(Month) (Day) (Year)
(c) Place: Burial or cremation Rural Cem.-Southboro, Mass.
18. (a) Signature of funeral director Joseph M. McDonough
(b) Address 225 Hanover
Countersigned Howard A. Streeter
(Agent City Board of Health)
19. (a) 10-30-45 (Date rec. by City Bd. of Health) (b) 10-31-45 (Date rec. by Town or city clerk.)
Signature of Town or City Clerk M. J. Quinn
Clerk of Manchester, NH

MEDICAL CERTIFICATE

20. DATE OF DEATH: Month Oct. day 29
year 1945 hour 6 min. 30 m.
21. I HEREBY CERTIFY that I attended the deceased from Oct 2, 1945 to Oct 29, 1945
that I last saw h...e alive on Oct 29, 1945
and that death occurred on the date and hour stated above

	DURATION
Immediate cause of death	
Demetia	
Due to	
Senilis	
Due to	
Old age and melantholies	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically
Please write the causes of death clearly and legibly

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or Town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. SIGNATURE N. D. Michou
M.D. or other MD Date signed 10-30-45
Address 795 Elm St.

A true copy, Attest: M. J. Quinn
Clerk of Manchester Dated Nov. 1, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important.

Form V. S. 19A
10-44—10M
6079

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100M-E-2-42-8855

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: (County) Worcester; (City or Town) Santa Margherita; No. Ospedale; St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Julius Trivelli (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Ospedale St. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution (Before death) —0— years months days. (Specify whether) In this community 30 yrs. + mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: married

5a If married, widowed, or divorced HUSBAND of Edmunda C. Cardarelli (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive 74 years

7 IF STILLBORN, enter that fact here.

8 AGE 81 Years 6 Months 22 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Laborer

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Prignano-Sannitico Italy

PARENTS

13 NAME OF FATHER Joseph Trivelli

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER

16 BIRTHPLACE OF MOTHER (City) (State or country) Mariannina Cardarelli Italy

17 Informant (Address) Frances Trivelli Same Relation, if any (Son)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tiefer (Signature of Agent of Board of Health or other)

Burial Agent Nov 11 1945 (Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 11 1945 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Nov 11, 1945; last saw h. alive on Nov 11, 1945; death is said to have occurred on the date stated above, at 1.35 P m.

	Duration
Immediate cause of death: Myocarditis chronic	10 years
Due to: Arteriosclerosis Chronic	2 -
Due to:	
Other conditions. Nephritis chronic (Include pregnancy within 3 months of death)	6 years

IMPORTANT

Major findings: Of operations none Date of
Of autopsy none
What test confirmed diagnosis? Physical Examination

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Wm. M. Tighe, M. D.
(Address) 9 Central Street Marlboro Date Nov 11 1945

21 Rural Southboro mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov 14 1945

22 NAME OF FUNERAL DIRECTOR Wm. M. Tighe
ADDRESS Marlboro Mass

Received and filed ..... 19.....
(Registrar)

FORM R-303A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

25m-10-39. No. 8427-i

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Parkerville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Samuel Clark (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) no

(a) Residence. No. Parkerville Rd St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution — (Specify whether) years — months — days. In this community 41 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Lucy E. Thompson (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 91 Years 1 Months 25 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Farmer Retired

10 Industry or Business: own farm

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Hartford Vermont

PARENTS

13 NAME OF FATHER William Clark

14 BIRTHPLACE OF FATHER (City) (State or country) Hartford Vermont

15 MAIDEN NAME OF MOTHER Eveline Porter

16 BIRTHPLACE OF MOTHER (City) (State or country) Hartford Vermont

17 Informant (Address) Mrs Lucy E. Clark Parkerville Rd Southboro (Relation, if any) wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Peters (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Dec 7 1945 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec (Month) 5 (Day) 1945 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19.....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? ..... Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Walter F. McInerney, M. D.

(Address) Westborough Date Dec 8 19 45

22 Rural Cemetery Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Dec 10 19 45

23 NAME OF FUNERAL DIRECTOR Irving M. Harper

ADDRESS West Main St Westboro

Received and filed Dec 11 1945

Marjorie F. McDonald (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK -- THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

30m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 215

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town); No. 35 West St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice F. Jennison (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Latisquama Rd. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 1 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Walter Jennison (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: own home

11 Social Security No. none

12 BIRTHPLACE (City) East Attleboro (State or country) Mass.

PARENTS

13 NAME OF FATHER: George P. Nourse

14 BIRTHPLACE OF FATHER (City) West Medway (State or country) Mass.

15 MAIDEN NAME OF MOTHER: Anna Smith

16 BIRTHPLACE OF MOTHER (City) Attleboro (State or country) Mass.

17 Informant Mrs. Clarence Wood (Relation, if any) (daughter)
(Address) Hopkinton, Mass.

A TRUE COPY.
ATTEST: Annie A. Dunne
(Registrar of city or town where death occurred)

DATE FILED Dec. 19 1945

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec. 18, 1945 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1945, to Dec. 17, 1945
I last saw her alive on Dec. 17, 1945, death is said to have occurred on the date stated above, at 7:45 a. m.

Immediate cause of death ..... Duration
Cardiac Decompensation ..... Dec 8/45
Due to Chronic myocarditis
Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) W. J. Cochrane, M. D.
(Address) Westboro, Mass. Date 12/18 1945

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural (Cemetery) Southboro (City or Town)
DATE OF BURIAL Dec. 20 1945

22 NAME OF FUNERAL DIRECTOR Irving W. Harper
ADDRESS Westboro, Mass.

Received and filed Dec 12 19 46 19
(Registrar of City or Town where deceased resided)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m (g)-1-41-4067

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. .....

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Southville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mark C. Corwin (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR) World I

(a) Residence. No. Southville Rd. St. ..... (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution — years — months — days. In this community 20 yrs. — mos. — days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Esther Humphreys (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 48 Years 1 Months 21 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Clerk

10 Industry or Business: Water Dept. City of Boston

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Charlestown Mass.

PARENTS

13 NAME OF FATHER: Walter Corwin

14 BIRTHPLACE OF FATHER (City) (State or country): Charlestown Mass.

15 MAIDEN NAME OF MOTHER: Alice Whittier

16 BIRTHPLACE OF MOTHER (City) (State or country): Charlestown Mass

17 Informant (Address): Mrs. Esther Corwin Southville Rd. Southboro Mass. Relation, if any: Wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tefft
(Signature of Agent of Board of Health or other)

Burial Agent
(Official Designation)

Dec 28, 1945
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Dec (Month) 21 (Day) 1945 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....
Date of occurrence ..... 19 .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury .....
Nature of Injury .....
While at work? ..... Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Walter F Mahoney, M. D.
(Address) Westborough Date Dec 22 1945

22 Woodlawn Everett Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec. 24 1945

23 NAME OF FUNERAL DIRECTOR Irving W. Harper
ADDRESS 42 West Main St Waltham Mass.

Received and filed Dec. 24 1945
Marjorie F. McDonald
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK – THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY

DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough (City or town making return)

Registered No. .....

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Susie Geneva (Tyler) Pethick (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) .....

(a) Residence. No. West Main St St. Southboro, Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) Hospital (Specify whether) years 5 months days. In this community 22 yrs. 5 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Raymond I. Pethick
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 75 Years 8 Months 29 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: at home

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Damascus, Penn

PARENTS

13 NAME OF FATHER Joseph Tyler

14 BIRTHPLACE OF FATHER (City) (State or country) Damascus, Penn

15 MAIDEN NAME OF MOTHER Harriet Mitchell

16 BIRTHPLACE OF MOTHER (City) (State or country) Tyler Hill, Penn

17 Informant Olga Pethick (Address) Southboro Daughter (Signature)

A TRUE COPY. F. J. Bertrand
ATTEST: .....
(Registrar of city or town where death occurred)

DATE FILED Jan 3, 1946

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec 22, 1945 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1945, to Dec 22, 1945

I last saw her alive on Dec 21, 1945 death is said to have occurred on the date stated above, at 2.00 P m.

Immediate cause of death Carcinoma of bladder — Duration 1 Yr

Due to .....

Due to .....

Other conditions. Bronchopneumonia Dec 18, 1945
(Include pregnancy within 3 months of death)

Major findings: Carcinoma of bladder
Of operations ..... Date of July 30-45

Of autopsy .....

What test confirmed diagnosis? Clinical

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) N. John Colombo M. D.

(Address) Hudson, Mass Date 12/28/45

21 PLACE OF BURIAL, CREMATION OR REMOVAL Hillside Cemetery (Cemetery) Damascus, Penn (City or Town)

DATE OF BURIAL Dec 26, 1945

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Marlborough, Mass

Received and filed Jan 3, 1945

Margaret Lyn Bonnell
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No.....

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Angelina McCarthy (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR).....

(a) Residence. No. Boston Road St. Southboro (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution Hospital (Specify whether) years months 6 days. In this community 35 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Michael J. McCarthy (Husband's name in full)

6 Age of husband or wife if alive 54 years

7 IF STILLBORN, enter that fact here.

8 AGE 50 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: At home

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) Marlboro (State or country) Mass.

PARENTS

13 NAME OF FATHER Elias Daufault

14 BIRTHPLACE OF FATHER (City) (State or country) Canada

15 MAIDEN NAME OF MOTHER Cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) Cannot be learned

17 Informant (Address) Mrs. A. Littlefield Relation, if any (daughter) Southboro, Mass.

A TRUE COPY.
ATTEST: Wm A. Walsh
(Registrar of city or town where death occurred)

DATE FILED December 31, 1945

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December (Month) 29, (Day) 1945 (Year)

19 I HEREBY CERTIFY, That I attended deceased from December 25, 1945 to December 30 1945

I last saw h...er alive on Dec. 24, 1945, death is said to have occurred on the date stated above, at 1:45a. m.

	Duration
Immediate cause of death Peritonitis	
acute supperative	4 days
Appendicitis	
Due to acute gangrenous ruptured	5 days
Rheumatic heart disease	40yrs.
Due to Mitral stenosis with	
heart failure, rt. sided.	6days

Other conditions (Include pregnancy within 3 months of death)

Major findings: Peritonitis acute
Of operations generalized ruptured appendicitis acute Date of 12/28/45
Of autopsy Same plus broncho pneumonia
What test confirmed diagnosis?

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Lee G. Kendall, M. D.
(Address) Framingham Date 12/31 1945

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural, Southboro (Cemetery) (City or Town)
DATE OF BURIAL January 2, 1945

22 NAME OF FUNERAL DIRECTOR William M. Tighe
ADDRESS Marlboro, Mass.

Received and filed Jan 10 1946
Maime F. McDonald.
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 1

1 PLACE OF DEATH: Middlesex (County); Marlborough (City or Town); No. Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Josephine Russell (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Turnpike Road St. Fayville (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution (Before death) years months 10 days. (Specify whether) In this community 16 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of Fred H. Russell (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 88 Years 11 Months 20 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At home

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Durham, N. H.

PARENTS

13 NAME OF FATHER: Unobtainable

14 BIRTHPLACE OF FATHER (City) (State or country): Unobtainable

15 MAIDEN NAME OF MOTHER: Unobtainable

16 BIRTHPLACE OF MOTHER (City) (State or country): Unobtainable

17 Informant (Address) Earl C. Russell Turnpike Rd, Fayville (Relation, if any) Son

A TRUE COPY. F. J. Bertrand
ATTEST: (Registrar of city or town where death occurred)

DATE FILED 1-3-46

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January 1 (Month) (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1945, to Jan 1, 1946

I last saw her alive on Jan 1, 1946, death is said to have occurred on the date stated above, at 8 P. m.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: years

Due to: Gen. Arteriosclerosis

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: Date of:

Of autopsy:

What test confirmed diagnosis? Phy. Exam.

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Wm. D. Roche, M. D.

(Address) Marlboro., Mass. Date 1/1/46

21 PLACE OF BURIAL, CREMATION OR REMOVAL Newton (Cemetery) Newton (City or Town)

DATE OF BURIAL Jan 3, 1946

22 NAME OF FUNERAL DIRECTOR Frederick Cookson

ADDRESS 318 Union Ave, Framingham

Received and filed Jan 3, 1946

(Registrar of City or Town where deceased resided)

M R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. chap. 46, section 10, requires physicians to insert a recital to that effect.

50m-(e)-6-43-12056

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return)

Registered No. 2

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Southville Rd Southboro St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Martha Thoits nee Lindsay
(If deceased is a married, widowed or divorced woman, give also maiden name.)

Physician — Important (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Rd St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community 46 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Greeley Thoits (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Home

10 Industry or Business: —

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Ireland

PARENTS

13 NAME OF FATHER can not be Learned

14 BIRTHPLACE OF FATHER (City) (State or country) " " " "

15 MAIDEN NAME OF MOTHER " " " "

16 BIRTHPLACE OF MOTHER (City) (State or country) " " " "

17 Informant David Thoits (Address) Southville Rd Southboro mass Relation, if any Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James L. Tighe
(Signature of Agent of Board of Health or other)

Burial Agent Jan. 6 1946
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan 5 1946
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary sclerosis

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of injury

Nature of injury

While at work? Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F McInney, M. D.

(Address) Westborough Date Jan 5 1946

22 Rural Southboro mass
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Jan 9 1946

23 NAME OF FUNERAL DIRECTOR Wm M Tighe

ADDRESS Marlboro Mass

Received and filed Jan 7 19 46

Mabel F. McInnes
A TRUE COPY ATTEST: (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER (City or town making return)

Registered No. 3

1 PLACE OF DEATH: WORCESTER (County); WORCESTER (City or Town)

No. Worc City Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Arthur Taylor (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Newton St St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution Hosp (Before death) (Specify whether) years 1 months 29 days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Ada Pearse (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 43 years

7 IF STILLBORN, enter that fact here.

8 AGE 47 Years 6 Months 25 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Milk Inspector

10 Industry or Business: Laboratory

11 Social Security No. 019-10-6311

12 BIRTHPLACE (City) (State or country) Framingham

PARENTS

13 NAME OF FATHER: Howard M Taylor

14 BIRTHPLACE OF FATHER (City) ---
(State or country) Maine

15 MAIDEN NAME OF MOTHER: Lucy Baker

16 BIRTHPLACE OF MOTHER (City) Westminster
(State or country)

17 Informant Mrs Ada Taylor Widow (Relation, if any)
(Address) Southboro

A TRUE COPY. ATTEST: Malcolm E McLay
(Registrar of city or town where death occurred)

DATE FILED Feb 9 1946

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb 6, 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1945, to Feb 6, 1946

I last saw him alive on Feb 6, 1946 death is said to have occurred on the date stated above, at 8.15am m.

Immediate cause of death: Pulmonary abscesses - rt — Duration: days

Due to: Carcinoma of Head of Pancreas — yrs

Due to: Pyelonephritis — mos

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: no

Date of autopsy: yes 2-6-46

What test confirmed diagnosis? Autopsy

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) George A MacIver Supt, M. D.

(Address) Worcester Date 2-6 1946

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Edgell Grove Framingham (Cemetery) (City or Town)

DATE OF BURIAL Feb 9 1946

22 NAME OF FUNERAL DIRECTOR: Irving W Harper

ADDRESS: Westboro

Received and filed Feb 8 1946

Maine E. McDonald
(Registrar of City or Town where deceased resided)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-(g)-1-45-15510

4

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 4

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Gray Swasey (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 29 Hayden Rowe St. (Usual place of abode) Hopkinton Mass. (If nonresident, give city or town and State)

Length of stay: In hospital or institution Yes (Before death) — years 4 months — days. (Specify whether) In this community 20 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widow

5a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of Fred F. Swasey (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 75 Years 8 Months 17 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: Own home

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Portland, Maine

PARENTS

13 NAME OF FATHER: Cannot be learned

14 BIRTHPLACE OF FATHER (City) (State or country) "

15 MAIDEN NAME OF MOTHER "

16 BIRTHPLACE OF MOTHER (City) (State or country) "

17 Informant: I. Blanche Chamberlain (Relation, if any: daughter)
(Address) 29 Hayden Rowe St.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tyler
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) 3/5/46 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: March (Month) 4 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1941, to Mar. 4, 1946.

I last saw her alive on March 3, 1946 death is said to have occurred on the date stated above, at 7.30 A. m.

	Duration
Immediate cause of death	IMPORTANT
Paralusis Agitans	4 yrs.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	IMPORTANT
Major findings: Of operations	Physician
Date of	Underline the cause to which death should be charged statistically.
Of autopsy	
What test confirmed diagnosis?	

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) L. F. Playe, M. D.
(Address) Hopkinton, Mass. Date 3/4 1946

21 Harmony Grove Portsmouth N.H.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 6, 1946

22 NAME OF FUNERAL DIRECTOR Vernon E. Morrill
ADDRESS 15 Church St. Hopkinton, Mass.

Received and filed April 1. 1946
(Registrar)

FORM R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. chap. 46, section 10, requires physicians to insert a recital to that effect.

50m-(e)-6-43-12056

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6 (City or town making return)

Registered No. 5

1 PLACE OF DEATH: Worcester (County); Southbridge (City or Town); No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna Farrell (If deceased is a married, widowed or divorced woman, give also maiden name.)

Physician — Important (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Katsiquamo Rd. St. Southbridge (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community 2 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): single

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 89 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: At home

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Canada

PARENTS

13 NAME OF FATHER Philip Farrell

14 BIRTHPLACE OF FATHER (City) (State or country) Canada

15 MAIDEN NAME OF MOTHER Jane Campbell

16 BIRTHPLACE OF MOTHER (City) (State or country) Canada

17 Informant (Address) John C. Grimes Rutland Vermont (Relation, if any) nephew

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James L. Peeler (Signature of Agent of Board of Health or other)

Burial Agt. (Official Designation) 3/8-46 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 7 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of injury

Nature of injury

While at work? Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date Mar 7 1946

22 St Michael Cemetery Hudson
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL March 9 1946

23 NAME OF FUNERAL DIRECTOR Harold A. Fiske

ADDRESS 50 Central St Hudson, Mass

Received and filed April 1 1946

A TRUE COPY ATTEST: (Registrar)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m (g)-1-41-4067

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 6

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. School St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Albert Jay Hill
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR) no

(a) Residence. No. 216 Park Ave St. Medina New York
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution 4 years — months 2 days. (Before death) (Specify whether) In this community — yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 57 Years 3 Months 7 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Teacher

10 Industry or Business: Private School

11 Social Security No. none

12 BIRTHPLACE (City) (State or country): Medina New York

PARENTS

13 NAME OF FATHER: Albert J. Hill

14 BIRTHPLACE OF FATHER (City) (State or country): Knoxville New York

15 MAIDEN NAME OF MOTHER: Florence Ryan

16 BIRTHPLACE OF MOTHER (City) (State or country): Medina New York

17 Informant: Mrs. J. J. Thompson (Relation, if any: sister)
(Address) 216 Park Ave Medina N.Y.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Telfer
(Signature of Agent of Board of Health or other)
Burial Agent 3/8/46
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: March 7 1946
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Carbon-monoxide poisoning

20 Accident, suicide, or homicide (specify) Suicide
Date of occurrence March 7 1946
Where did Injury occur? Southborough Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? St Marks School Garage
(Specify type of place)
Manner of Injury Inhalation auto exhaust gas
Nature of Injury asphyxiation
While at work? no Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Walter F Hutchinson M. D.
(Address) Westborough Date Mar 8 1946

22 Boxwood Medina New York
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 11 1946

23 NAME OF FUNERAL DIRECTOR Irving W. Harper
ADDRESS 62 West Main St Westborough

Received and filed April 1 1946
Frances E Roberts
(Registrar)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m (8)-1-41-4067

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 7

1 PLACE OF DEATH
(County) Worcester
(City or Town) Southbury
No. Boston - Worcester Turnpike St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harold Lewis Bradford
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) no

(a) Residence. No. Reynolds St. Danielson, Conn.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution — years — months — days. In this community — yrs. — mos. — days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): divorced

5a If married, widowed, or divorced
HUSBAND of Edith Nash
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

6 Age of husband or wife if alive — years

7 IF STILLBORN, enter that fact here.

8 AGE 34 Years 3 Months 27 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Electrician

10 Industry or Business: Electrical contracting

11 Social Security No. 049-01-3906

12 BIRTHPLACE (City) (State or country) Danielson Conn.

PARENTS

13 NAME OF FATHER: Lewis A. Bradford

14 BIRTHPLACE OF FATHER (City) (State or country): Danielson Conn.

15 MAIDEN NAME OF MOTHER: Eva Gardner

16 BIRTHPLACE OF MOTHER (City) (State or country): Danielson Conn.

17 Informant (Address) Lewis A. Bradford Danielson, Conn. Relation, if any (Father)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tiefer
(Signature of Agent of Board of Health or Other)
Burial Agent - 3/17/46
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: March (Month) 17 (Day) 1946 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture Skull

20 Accident, suicide, or homicide (specify) Accident
Date of occurrence March 17 19 46
Where did Injury occur? Southbridge Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Highway
(Specify type of place)
Manner of Injury: Automobile tipped over
Nature of Injury: Fract Skull
While at work? no Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Walter F Mahoney, M. D.
(Address) Brattleboro Date March 17 1946

22 Westfield Danielson Conn.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 21, 1946

23 NAME OF FUNERAL DIRECTOR: Frank A. Harper
ADDRESS 67 N. Main St. Southbridge Mass.

Received and filed April 1 1946
John J. Rabeny
Town Clerk
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Fall River (City or town making return)

Registered No. 12 78

1 PLACE OF DEATH: Bristol (County); Fall River (City or Town); No. Rose Hawthorne Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Patrick J. O'Reilly (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Boston Rd. St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution home years 1 months 8 days. In this community yrs. mos. days. (Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of Mary F. Maley (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 85 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired

10 Industry or Business: Metropolitan Dept.

11 Social Security No.

12 BIRTHPLACE (City) (State or country): Ireland

PARENTS

13 NAME OF FATHER: John O'Rielly

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Catherine Moriaty

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant: John F. O'Rielly (Address) (Relation, if any): son

A TRUE COPY. ATTEST: Erick F. Bergeson (Registrar of city or town where death occurred)

DATE FILED 3/29/46 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: March 20, 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 19 46 to March 20, 19 46

I last saw him alive on March 19, 46, death is said to have occurred on the date stated above, at 2:10A. m.

Immediate cause of death: Cancer of prostate gland — Duration: 1/1943

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Cancer

Of operations — Date of

Of autopsy

What test confirmed diagnosis? Microscopic

20 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph G. Norman, M. D.

(Address) 1675 So. Main Date 3/20/19 46

Physician: Underline the cause to which death should be charged statistically.

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Hill Cem., Southboro, Mass. (Cemetery) March 23, 1946 (City or Town)

DATE OF BURIAL 19

22 NAME OF FUNERAL DIRECTOR: Wm. Tighe

ADDRESS Marlboro Mass.

Received and filed June 12 1946

(Registrar of City or Town where deceased resided) E.

M R-301 A

...ate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

be carefully supplied. AGE should be stated EXACTLY. PHY...

50m-(e)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registrar's No. 8

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Middle Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Annie Vietta (Benjamin) Stivers (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Middle Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community 59 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Widowed

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of William H. Stivers (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 6 Months 7 Days | If less than 1 day Hours Minutes

9 Usual Occupation: At home

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country): White Rock, Kings County Nova Scotia

PARENTS

13 NAME OF FATHER: Alan Benjamin

14 BIRTHPLACE OF FATHER (City) (State or country): Nova Scotia

15 MAIDEN NAME OF MOTHER: Mary Pick

16 BIRTHPLACE OF MOTHER (City) (State or country): Nova Scotia

17 Informant (Address): Sarah V. Stivers Middle Rd., Southboro Relation, if any: Daughter

was filed with me BEFORE the burial or transit permit was issued:
I HEREBY CERTIFY that a satisfactory standard certificate of death

James F. Peeler
(Signature of Agent of Board of Health or other)
Agent
(Official Designation)
4/15/46
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: April (Month) 13 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June, 1939, to April 13, 1946
I last saw her alive on April 13, 1946, death is said to have occurred on the date stated above, at 10:30 P.M.

Immediate cause of death: Coronary occlusion (Thrombosis) — Duration IMPORTANT: 3-

Due to: Arteriosclerosis — 2-

Due to:

Other conditions: none (Include pregnancy within 3 months of death) IMPORTANT

Major findings: Of operations: Date of:

Of autopsy: Physical exam

What test confirmed diagnosis? X-ray

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Roland L. Vautier, M. D.
(Address) Worcester Date 4/14 1946

21 Burial Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 16, 1946

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 156 Otting Ave., Marlboro Mass.

Received and filed April 18 1946
(Registrar)

FORM R-301 A

N.B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 9

1 PLACE OF DEATH: ~~Worcester~~ ~~Westborough~~ (County) Fayville (Southboro) (City or Town) No. Oak Hill Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

HAZELTON

2 FULL NAME Clara A. (FAY) Pierpont (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Oak Hill Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months days. In this community 6 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of LAWRENCE PIERPONT (Husband's name in full)

6 Age of husband ~~or wife~~ if alive 72 years

7 IF STILLBORN, enter that fact here.

8 AGE 68 Years 10 Months 10 Days If less than 1 day Hours Minutes

9 Usual Occupation: Homemaker

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or Country) Brookline Mass

PARENTS

13 NAME OF FATHER: HARRY FRANK FAY

14 BIRTHPLACE OF FATHER (City) (State or Country) Chelsea Mass

15 MAIDEN NAME OF MOTHER: MARY CORNELIA HULL

16 BIRTHPLACE OF MOTHER (City) (State or Country) Hartford Conn. ~~Mass~~

17 Informant LAWRENCE PIERPONT (Relation, if any) HUSBAND (Address) OAK HILL ROAD - FAYVILLE. MASS

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Fella (Signature of Agent of Board of Health or other)

Burial Agent May 5, 1946 (Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: May (Month) 5 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1945, to May 5, 1946

I last saw her alive on May 4, 1946, death is said to have occurred on the date stated above, at 3:05 a m.

Immediate cause of death: Metastatic Carcinoma of brain — Duration IMPORTANT 4 days

Due to Generalized carcinomatosis — 18 months

Due to (CA of Breast 18 yrs ago)

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations — Date of

Of autopsy

What test confirmed diagnosis? XRAY of Bones.

IMPORTANT — Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Allan P. Silcox, M. D.

(Address) 270 Main St - Northboro Mass Date May 5 1946

21 WOODLAWN CREMATORY EVERETT MASS (Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL TUES - MAY 7. 1946

22 NAME OF FUNERAL DIRECTOR Robert K Wadsworth

ADDRESS 53 BEECH ST - Framingham MASS

Received and Filed May 7 1946

John J. Rabenn (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

...s of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased ...d in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk ... the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

...(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 123 10 13

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town); No. Church St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clara Isetta Lincoln (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) no

(a) Residence. No. Wood St. Southville St. Southborough
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community yrs. mos. 12 days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Paul Lincoln (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 87 Years 2 Months 14 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: housewife

10 Industry or Business: home

11 Social Security No. none

12 BIRTHPLACE (City) (State or country): Denmark Maine

PARENTS

13 NAME OF FATHER: -- Hill

14 BIRTHPLACE OF FATHER (City) (State or country): West Paris Maine

15 MAIDEN NAME OF MOTHER: cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country): cannot be learned

17 Informant (Address) Howard R. Lincoln (Relation, if any) son

A TRUE COPY.
ATTEST: Annie A. Dunne
(Registrar of city or town where death occurred)

DATE FILED May 14, 1946

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May 12, 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 30, 1946, to May 12, 1946.
I last saw her alive on May 12, 1946 death is said to have occurred on the date stated above, at 3 p. m.

	Duration
Immediate cause of death: myocarditis chronic	?
Due to: arterio sclerosis chronic	?
Due to:	
Other conditions (Include pregnancy within 3 months of death): Endosteitis right leg 3 weeks	

Major findings: Of operations: none Date of .....
Of autopsy: none
What test confirmed diagnosis? physical exam.

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....

(Signed) Roland S. Newton M. D.
(Address) Westboro, Mass. Date May 12 1946

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Rural Cemetery, Southboro
(Cemetery) (City or Town)
DATE OF BURIAL 15 May 1946

22 NAME OF FUNERAL DIRECTOR J. F. Sargeant
ADDRESS 15 Church St. Hopkinton

Received and filed 1946
(Registrar of City or Town where deceased resided)

FORM R-302

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 11

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Suzanne Streagle (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Lynbrook Farm St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution Hospital years months 2 days. In this community yrs. mos. 2 days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE ..... Years ..... Months 2 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation:

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Framingham Mass.

PARENTS

13 NAME OF FATHER Aris Streagle

14 BIRTHPLACE OF FATHER (City) Matewan (State or country) West Virginia

15 MAIDEN NAME OF MOTHER Grace Bogart

16 BIRTHPLACE OF MOTHER (City) Marlboro (State or country) Mass.

17 Informant Aris Streagle (Relation, if any father)
(Address) Southboro, Mass.

A TRUE COPY.
ATTEST: [signature] (Registrar of city or town where death occurred)
DATE FILED May 22, 1946

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May (Month) 17, (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 15, 1946, to May 17, 1946.
I last saw her alive on May 17, 1946 death is said to have occurred on the date stated above, at 11:30a. m.

	Duration
Immediate cause of death: Congenital malformation of heart.	
Due to:	
Due to:	
Other conditions: Prematurity (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Date of
Of autopsy as above
What test confirmed diagnosis? post mortem

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Joseph C. Merriam, M. D.
(Address) Framingham Date 5/17 1946

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural (Cemetery) Southboro (City or Town)
DATE OF BURIAL May 20, 1946

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS 15 Cotting Ave., Marlboro

Received and filed June 1, 1946
John J. Baker (Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 12

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Infant Girl Brown (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Latisquama Road St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution Hospital (Before death) (Specify whether) years 11hrs. months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE ..... Years ..... Months ..... Days | If less than 1 day 11 Hours ..... Minutes

9 Usual Occupation: .....

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) Framingham (State or country) Mass.

PARENTS

13 NAME OF FATHER Thomas L. Brown

14 BIRTHPLACE OF FATHER (City) Westboro (State or country) Mass.

15 MAIDEN NAME OF MOTHER Marilyn J. Baker

16 BIRTHPLACE OF MOTHER (City) Erie (State or country) Pennsylvania

17 Informant Thomas L. Brown (Relation, if any) (father)
(Address) Southboro

A TRUE COPY.
ATTEST: Wm. L. Walsh
(Registrar of city or town where death occurred)

DATE FILED May 27, 1946

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May (Month) 25, (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 25, 1946, to May 25, 1946
I last saw her alive on May 25, 1946 death is said to have occurred on the date stated above, at 10:53p. m.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Grace E. Tiffany, M. D.
(Address) 284 Union Ave. Date 5/27 1946

21 PLACE OF BURIAL, CREMATION OR REMOVAL St. Lukes. (Cemetery) Westboro (City or Town)
DATE OF BURIAL May 27, 1946

22 NAME OF FUNERAL DIRECTOR F. A. Cookson
ADDRESS Framingham, Mass.

Received and filed 1946
John J. Baker
(Registrar of City or Town where deceased resided)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No. 13

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town)
No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clarence Albert Thomas (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) World War I

(a) Residence. No. Southville Rd. St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community / yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 56 Years 1 Months 6 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Shoemaker

10 Industry or Business: Shoe

11 Social Security No. 017-05-4736

12 BIRTHPLACE (City) (State or country) Framingham Mass

PARENTS

13 NAME OF FATHER Everett A. Thomas

14 BIRTHPLACE OF FATHER (City) (State or country) Leominster Mass.

15 MAIDEN NAME OF MOTHER Lena Bella Taylor

16 BIRTHPLACE OF MOTHER (City) (State or country) Rufesford Nova Scotia

17 Informant Charles Thomas (Relative if any) (Address) Southville Rd., Southville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James L. Tufts
(Signature of Agent of Board of Health or other)

Burial Agent 7-20-46
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 19 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 10, 1946 to July 19, 1946
I last saw him alive on July 19, 1946 death is said to have occurred on the date stated above, at 11:15 A.M.

Immediate cause of death Chronic myocarditis — Duration

Due to arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none Date of

Of autopsy none

What test confirmed diagnosis? Examination

IMPORTANT Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) C. W. Lanctot, M. D.
(Address) Southboro Date July 19 1946

21 Marlborough Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 21, 1946

22 NAME OF FUNERAL DIRECTOR Summers B. Gage
ADDRESS Marlboro, Mass.

Received and filed July 22 1946
John J. Roberts (Registrar)

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

WORCESTER
(City or town making return)

Registered No. 14

1 PLACE OF DEATH
WORCESTER (County)
WORCESTER (City or Town)
No. St Vincent Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Batista Berri (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Cherry St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution hospital years months 10 days. In this community yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: married

5a If married, widowed, or divorced
HUSBAND of Maria Dallavalle
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

6 Age of husband or wife if alive 55 years

7 IF STILLBORN, enter that fact here.

8 AGE 65 Years 11 Months — Days | If less than 1 day Hours Minutes

9 Usual Occupation: Laborer

10 Industry or Business:

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Italy

PARENTS

13 NAME OF FATHER Joseph Berri

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) Italy

17 Informant (Address) Widow Southboro (Relation, if any)

A TRUE COPY.
ATTEST: Malcolm E. McLeay
(Registrar of city or town where death occurred)

DATE FILED July 24, 1946

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 22, 1946
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 13, 1946, to July 22, 1946
I last saw him alive on July 22, 1946, death is said to have occurred on the date stated above, at 8:40 p. m.

Immediate cause of death	Duration
Uremia	14 dys
Due to Chr. Interstitial nephritis	1 yr
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations ... Date of ... Of autopsy ... What test confirmed diagnosis?	

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Eugene L Richmond, M. D.
(Address) Worcester Date 7-22 1946

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Southboro
(Cemetery) (City or Town)
DATE OF BURIAL July 25, 1946 19

22 NAME OF FUNERAL DIRECTOR Wm. M. Tighe
ADDRESS Marlboro

Received and filed August 15 1946
(Registrar of City or Town where deceased resided)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m-(1)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 15

1 PLACE OF DEATH: Worcester (County) Oxbridge (City or Town) No. Highland Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Daniel F Kelley (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Highland Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of Grace Emerson (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 52 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Machinist

10 Industry or Business:

11 Social Security No. 003-12-0969

12 BIRTHPLACE (City) (State or country) Oxbridge Massachusetts

PARENTS

13 NAME OF FATHER Daniel Kelley

14 BIRTHPLACE OF FATHER (City) (State or country) Hopkinton Massachusetts

15 MAIDEN NAME OF MOTHER Julia M Calnan

16 BIRTHPLACE OF MOTHER (City) (State or country) Marlboro Massachusetts

17 Informant (Address) Robert Kelley Oxbridge Relation, if any Brother

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Keefe (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) July 26-46 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 25 (Day) 1946 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury

Nature of Injury

While at work? Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Walter F Mahoney, M. D.

(Address) Westboro Date July 25 1946

22 Woodland Keene N.H. Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL July 27 1946

23 NAME OF FUNERAL DIRECTOR J. F. Callanan & Son

ADDRESS Hopkinton Mass.

Received and filed July 26 1946

Clarence E Rabern Asst (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

RUTLAND (City or town making return)

Registered No. 1946

1 PLACE OF DEATH: WORCESTER (County); RUTLAND (City or Town); No. Rutland State Sanatorium St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas Joseph Sheehan (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Walker St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Sanatorium (Before death) (Specify whether) years 6 months 11 days. In this community yrs. 6 mos. 11 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Caucasian

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE 45 Years 8 Months 18 Days | If less than 1 day ... Hours ... Minutes

9 Usual Occupation: Watchmaker

10 Industry or Business:

11 Social Security No. 029-20-1068

12 BIRTHPLACE (City) (State or country) Ireland

PARENTS

13 NAME OF FATHER: Michael Sheehan

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER: Margaret Collins

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) State San. Records (Relation, if any)

A TRUE COPY.
ATTEST: Frances P. Hanly
(Registrar of city or town where death occurred)
DATE FILED August 6, 1946 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH August (Month) 5 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from January 25, 1946, to August 5, 1946

I last saw him alive on August 5, 1946, death is said to have occurred on the date stated above, at 9:30 A.M.

Immediate cause of death	Duration
Tuberculosis of the lungs	8 years
Due to Dilatation of heart due to pulmonary disease	
Due to Hypertensive cardio-vascular disease	1 year
Due to	

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations ... Date of ... Of autopsy ...

What test confirmed diagnosis? X-ray & lab.

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? ...

If so, specify Unknown

(Signed) Heinz J. Lorge, M. D.

(Address) Rutland State San Date 8/5 1946

21 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge, Cambridge, Mass (Cemetery) (City or Town)

DATE OF BURIAL August 7, 1946 19

22 NAME OF FUNERAL DIRECTOR Frank H. Miles Co.

ADDRESS Jefferson, Mass.

Received and filed Aug September 5 1946

(Registrar of City or Town where deceased resided)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

100m-2-'40-D-729-a

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 17

PLACE OF DEATH

1 Worcester (County)

Southborough (City or Town)

No. East Main St. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary E. (Burke) Boland (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. E. Main St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of William J. Boland (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No.

12 BIRTHPLACE (City) (State or country): Ireland

PARENTS

13 NAME OF FATHER: John P. Burke

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Elizabeth Doyle

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address) John F. Boland E. Main St. Southboro Relation, if any (Son)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Leefer (Signature of Agent of Board of Health or other)

Burial Agent. (Official Designation) Aug. 16. 1946 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Aug. (Month) 14 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 1, 1936, to Aug. 14, 1946, I last saw h[er] alive on Aug 14, 1946, death is said to have occurred on the date stated above, at 5.00 P. m.

Immediate cause of death: Arteriosclerosis — Duration 10 yrs.

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations: Date of:
Of autopsy:
What test confirmed diagnosis? Physical findings

IMPORTANT — PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify:
(Signed) William J. Delaney, M. D.
(Address) 186 Main St. Date Aug. 15, 1946

21 Rural Cemetery, Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL August 17, 1946

22 NAME OF FUNERAL DIRECTOR: John P. Rowe
ADDRESS: 57 Main St. Marlboro

Received and filed Aug. 16, 1946

John J. Sullivan (Registrar)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

30m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 18

1 PLACE OF DEATH: Worcester (County); Southborough (City or Town); No. Southville Rd - Cordaville St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Sora
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Southville Rd, Cordaville St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or Institution — years — months — days. In this community 356 yrs. 6 mos. — days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced HUSBAND of Gemma Borsetti (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 58 years

7 IF STILLBORN, enter that fact here.

8 AGE 58 Years 1 Months 2 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Boston + Albany R.R.

10 Industry or Business: Laborer

11 Social Security No. 714-10-6944

12 BIRTHPLACE (City) (State or country) Italy

PARENTS

13 NAME OF FATHER: Louis Sora

14 BIRTHPLACE OF FATHER (City) (State or country): Italy

15 MAIDEN NAME OF MOTHER: Marie Pasucci

16 BIRTHPLACE OF MOTHER (City) (State or country): Italy

17 Informant (Address) Mrs. Edward Sora Southville Rd. Cordaville (Relation, if any) Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Seeley
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Aug. 20, 1946 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH August 17th 1946
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Heart disease due presumably to Coronary Sclerosis

20 Accident, suicide, or homicide (specify) —
Date of occurrence — 19
Where did Injury occur? —
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? —
(Specify type of place)
Manner of Injury —
Nature of Injury —
While at work? no Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) M. John Colonto, M. D.
(Address) Hudson Mass. Date 8/19 1946

22 Rural Cemetery, Southborough
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Aug 20 1946

23 NAME OF FUNERAL DIRECTOR Eugene J. McCarthy
ADDRESS 11 Lincoln Street, Framingham, Mass

Received and filed Sept 9 1946 19
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

30m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

BOSTON (City or town making return)

Registered No. 8045 19

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town) No. Floating Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John C Taylor (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Cordaville Mass xxStxx (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE Years Months 5 Days | If less than 1 day Hours Minutes

9 Usual Occupation: -----

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Framingham Mass.

PARENTS

13 NAME OF FATHER: Cecil Taylor

14 BIRTHPLACE OF FATHER (City) (State or country): England

15 MAIDEN NAME OF MOTHER: Ida J Johnson

16 BIRTHPLACE OF MOTHER (City) (State or country): Worcester Mass.

17 Informant (Address): Mother (Relation, if any)

A TRUE COPY. ATTEST: Michael J. Manning (Registrar of city or town where death occurred)

DATE FILED Sept. 19 19 46

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH (Month) Sept. (Day) 14/46 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept. 10, 19 46, to Sept. 14 19 46

I last saw h im alive on Sept. 14, 19 46, death is said to have occurred on the date stated above, at ---- m.

Immediate cause of death: Cardio resp. failure — Duration

Due to: Prematurity and probable congenital heart

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations: Date of

Of autopsy: Congenital malformation of ht

What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) M J Foley, M. D.

(Address) 20 Ash St Boston Date 9-14 19 46

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Grove Cem-Milford Mass (Cemetery) (City or Town)

DATE OF BURIAL Sept. 18/46 19

22 NAME OF FUNERAL DIRECTOR: J F Sargeant

ADDRESS: Milford Mass.

Received and filed October 7 1946 19

John J Rabem

(Registrar of City or Town where deceased resided)

F&E

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 21

1 PLACE OF DEATH: (County) MIDDLESEX; (City or Town) MARLBOROUGH; No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Inft Anderson (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Latisquama Rd St. Southboro Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE .....Years.....Months.....Days | If less than 1 day .....Hours.....Minutes

9 Usual Occupation:

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Marlborough Mass

PARENTS

13 NAME OF FATHER: Vincent W. Anderson

14 BIRTHPLACE OF FATHER (City) (State or country) Belmont Mass

15 MAIDEN NAME OF MOTHER: Doreen P. Nichols

16 BIRTHPLACE OF MOTHER (City) (State or country) Yarmouth N.S.

17 Informant (Address) Vincent W. Anderson Latisquama Rd. Southboro Relation, if any Father

A TRUE COPY. F. J. Bertrand

ATTEST: (Registrar of city or town where death occurred)

DATE FILED Oct 25 1946 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Oct (Month) 17 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h.....alive on....., 19....., death is said to have occurred on the date stated above, at.....m.

Immediate cause of death..... Duration

stillborn

anencephalus

Due to spina bifida associated with

hydramenous in 7th month

Due to gestation

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations.....Date of.....
Of autopsy.....
What test confirmed diagnosis?.....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) W. Hood, M. D.
(Address) Hudson Mass Date 10-18-46

21 PLACE OF BURIAL CREMATION OR REMOVAL Maplewood /Cem (Cemetery) Marlborough (City or Town)
DATE OF BURIAL Oct 19 1946 19

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlborough Mass

Received and filed Nov 5 19 46
Frances E Raheen asst clerk
(Registrar of City or Town where deceased resided)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m (g)-1-41-4067

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 20

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Turnpike Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Premena Noborini nee Trioli
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full).
(or) WIFE of Louis Noborini
(Husband's name in full)

6 Age of husband or wife if alive ..... 60 years

7 IF STILLBORN, enter that fact here.

8 AGE 57 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Shoemaker

10 Industry or Business: .....

11 Social Security No. 024-10-0397

12 BIRTHPLACE (City) (State or country) Fayette Mass

PARENTS

13 NAME OF FATHER: John Trioli

14 BIRTHPLACE OF FATHER (City) (State or country): Italy

15 MAIDEN NAME OF MOTHER: Aminta Cordoni

16 BIRTHPLACE OF MOTHER (City) (State or country): Italy

17 Informant: Louis Noborini (Address) Turnpike Rd Fayette (Relation, if any) Husband

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Samuel Tucker
(Signature of Agent of Board of Health or other)

Burial Agent Oct 19 1946
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Oct (Month) 17 (Day) 1946 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary thrombosis

20 Accident, suicide, or homicide (specify) .....
Date of occurrence ..... 19 .....
Where did Injury occur? .....
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)
Manner of Injury .....
Nature of Injury .....
While at work? ..... Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Robert Newman, M. D.
(Address) Northboro Date Oct 17 1946

22 Rural Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Oct 21 1946

23 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed October 22 1946
John J Laherty
(Registrar)

FORM R-302

MIDDLESEX (County)

MARLBOROUGH (City or Town)

MARLBOROUGH (City or town making return)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 12

1 PLACE OF DEATH

No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles A. Depuy (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Newton St. St. Southboro Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months days. In this community yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced
HUSBAND of Julia Ehney (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 76 years

7 IF STILLBORN, enter that fact here.

8 AGE 88 Years 9 Months 5 Days | If less than 1 day Hours Minutes

9 Usual Occupation: automotive parts

10 Industry or Business: retired

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Rockford Ill

PARENTS

13 NAME OF FATHER Addison Depuy

14 BIRTHPLACE OF FATHER (City) (State or country) New York

15 MAIDEN NAME OF MOTHER Claret Chubb

16 BIRTHPLACE OF MOTHER (City) (State or country) Illinois

17 Informant Julia Depuy (Address) Newton St. Southboro (Relation, if any)

A TRUE COPY. ATTEST: F. J. Bertrand
(Registrar of city or town where death occurred)

DATE FILED Oct 31 1946 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Oct 27 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct 18, 1946 to Oct 27, 1946
I last saw him alive on Oct 27, 1946 Death is said to have occurred on the date stated above, at 7 P. m.

Immediate cause of death myocarditis — Duration 3 wks

Due to art scler — 10 yrs

Due to senility

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations Date of
Of autopsy
What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) J.D. Kable M. D.
(Address) W. Main St. Date 10-28-46

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cem Southboro (Cemetery)
DATE OF BURIAL Oct 30 1946 (City or Town) 19

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlborough Mass

Received and filed November 5 1946
Frances E. Roberts asst clerk
(Registrar of City or Town where deceased resided)

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

FORM R-301 A

N.B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 23

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Parkerville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry G. Benson
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Parkerville Rd. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months days. In this community 26 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed or divorced HUSBAND of Alice M. Kelley
(Give maiden name of wife in full)
(or) WIFE of
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years Months Days — If less than 1 day Hours Minutes

9 Usual Occupation: Caretaker

10 Industry or Business: Retired

11 Social Security No. —

12 BIRTHPLACE (City) (State or Country) East Braton Mass.

PARENTS

13 NAME OF FATHER: John Benson

14 BIRTHPLACE OF FATHER (City) (State or Country): Halifax England

15 MAIDEN NAME OF MOTHER: Elizabeth A. Nichols

16 BIRTHPLACE OF MOTHER (City) (State or Country): Halifax England

17 Informant (Address): Mrs. Joseph F. Cummings (Relation, if any) None
Parkerville Rd, Southboro Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Saul P. Henderson
(Signature of Agent of Board of Health or other)

Chairman (Official Designation) 11-9-46 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: November 8 1946
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1944, to Nov 8, 1946
I last saw him alive on Nov 8, 1946, death is said to have occurred on the date stated above, at 4 P. m.

	Duration
Immediate cause of death: Myocarditis Chronic	10 years
Due to: Arterio sclerosis Chronic	—
Due to:	
Other conditions (Include pregnancy within 3 months of death): none	

IMPORTANT

Major findings: Of operations: none — Date of
Of autopsy: none
What test confirmed diagnosis: Physical exam

IMPORTANT
Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Richard C Norton, M. D.
(Address) 9 Central Worcester Date Nov 9 1946

21 Woodlawn Everett Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov 12, 1946

22 NAME OF FUNERAL DIRECTOR: Irving N. Harper
ADDRESS 6 N. Main St. Southboro Mass

Received and Filed November 12 1946
Frances E. Rahuna
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No. 24

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. Fatisquama Road. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Irma Genette (Port) Cheney (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Fatisquama St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community 36 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert F. Cheney (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive 70 years

7 IF STILLBORN, enter that fact here.

8 AGE 80 Years 10 Months 10 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No.

12 BIRTHPLACE (City) Schenango Forks (State or country) New York

PARENTS

13 NAME OF FATHER Jesse Port

14 BIRTHPLACE OF FATHER (City) (State or country) N. Y. State

15 MAIDEN NAME OF MOTHER Merky Ann Heath

16 BIRTHPLACE OF MOTHER (City) (State or country) N. Y. State

17 Informant Robert F. Cheney Relation, if any Husband
(Address) Fatisquama Road, Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul F. Henderson
(Signature of Agent of Board of Health or other)

Chairman (Official Designation) 11-10-46 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 9 1946
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1925, to Nov 9, 1946

I last saw her alive on Nov 7, 1946, death is said to have occurred on the date stated above, at 5 P. M.

Immediate cause of death: Myocardial Insufficiency — Duration 1940

Due to: Arteriosclerosis Coronary — 2 —

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: none — Date of:

Of autopsy: none — What test confirmed diagnosis? Physical Exam

IMPORTANT

Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Roland L Weston, M. D.
(Address) 9 Buffum West Boro Date 11/10 1946

21 Fairmount Cemetery Lee Mass.
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL November 12, 1946

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS Marlboro Mass. (15 Lotting Ave)

Received and filed November 15 1946
Frances E Raheus (Registrar)

A TRUE COPY ATTEST:

RM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 25

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Middle Rd St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Catherine Carey nee Sullivan (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Middle Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 40 years ..... months ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Married

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF William Carey
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 75 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At Home

10 Industry or Business: —

11 Social Security No. —

12 BIRTHPLACE (City) (State or country) Ireland

PARENTS

13 NAME OF FATHER Jeremiah Sullivan

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER can not be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) " " " "

17. Informant (Address) Mrs Benedict Maguire Middle Rd Southboro Relation, if any Daughter

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Paul P. Henderson
(Signature of Agent of Board of Health or other)

Chairman
(Official Designation)

11-19-46
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov. 18 - 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Nov. 16 - 1946, to Nov. 18, 1946

I last saw h— alive on Nov. 18, 1946, death is said to have occurred on the date stated above, at 8.20 P M.

Duration Important

Immediate cause of death
Acute Myocarditis — 3 days

Due to Hypertensive Heart Disease and Degeneration — 7 years

Due to Myocardial Degeneration as possible Coronary Heart Disease

Other conditions Diabetes Mellitus Mg Titus
(Include pregnancy within 3 months of death) — Important

Major findings:
Of operations
Date of
Of autopsy
What test confirmed diagnosis? Phy ex.

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Clyde N. Merrill M.D.
(Address) Marlboro Mass Date Nov 19 1946

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov 21 1946

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed Nov. 25 1946
Frances E Cahern
(Registrar)

A TRUE COPY ATTEST:

FORM R-301 A

N. B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Hood St.

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 26

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Harriet E. Voter
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Hood St.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months days. In this community 74 yrs. 1 mos. 5 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of George Voter
(Husband's name in full)

6 Age of husband or wife if alive 64 years

7 IF STILLBORN, enter that fact here.

8 AGE 74 Years 1 Months 5 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: Own home

11 Social Security No.

12 BIRTHPLACE (City) Southboro (State or Country) Mass.

PARENTS

13 NAME OF FATHER: Warren C. Reed

14 BIRTHPLACE OF FATHER (City) Cannot be learned (State or Country) Cannot be learned

15 MAIDEN NAME OF MOTHER: Helen Burlingame

16 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or Country) Cannot be learned

17 Informant: Mrs. Leon Pierce (Relation, if any) Daughter
(Address) Hood St., Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Teeter
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation)

Dec 6, 1946 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Dec (Month) 5 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Mar 18, 1943, to Dec 5, 1946

I last saw her alive on Dec 4, 1946 death is said to have occurred on the date stated above, at 2:30 P m.

	Duration
Immediate cause of death: Congestive Heart Failure	2 mos
Due to: Rheumatic Heart Disease & Auric. fibrillation	5 yrs +
Due to	
Other conditions (Include pregnancy within 3 months of death)	

IMPORTANT

Major findings: Of operations — Date of
Of autopsy
What test confirmed diagnosis?

IMPORTANT
Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? If so, specify No

(Signed) Hugh Tolman, M. D.
(Address) 198 Lincoln Ave. Date Dec 6 1946

21 Burial Southboro, Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec 8, 1946

22 NAME OF FUNERAL DIRECTOR: Irving N. Harper
ADDRESS 6 N. Main St. Hopkinton, Mass.

Received and Filed December 9, 1946
James E Raheen
(Registrar)

RM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 27

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Main St St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Cornelia S Bouthillet
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Main St St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 50 years ..... months ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Single

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 70 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired Secretary

10 Industry or Business: School

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Burlington Vt

PARENTS

13 NAME OF FATHER Ulderic Bouthillet

14 BIRTHPLACE OF FATHER (City) (State or country) Canada

15 MAIDEN NAME OF MOTHER Caroline E Lemere

16 BIRTHPLACE OF MOTHER (City) (State or country) Canada

17 Informant James Hurley (Address) 17 Charles St Marlboro Mass Relation if any (nephew)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Teefy
(Signature of Agent of Board of Health or other)

Burial Agent Dec 14 1946
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December 13 1946
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1941 to Dec 13, 1946
I last saw h.. alive on Dec. 13, 1946 death is said to have occurred on the date stated above, at 7:30 M.

Immediate cause of death	Duration Important
Coronary Occlusion	4 hours
Due to Arteriosclerosis	5 years
Due to Mitral Regurgitation	5 years
Other conditions (Include pregnancy within 3 months of death)	Important

Major findings: Of operations —
Date of —
Of autopsy None
What test confirmed diagnosis? None

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Thomas E Reilly M.D.
(Address) Marlboro, Mass Date 12-14 1946

21 St Michael's Hudson Mass
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL Dec 16 1946

22 NAME OF FUNERAL DIRECTOR John M Tighe
ADDRESS Marlboro Mass

Received and filed Dec. 14 1946
John J. Baberi
(Registrar)

A TRUE COPY ATTEST

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(D)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

(City or town making return)

STANDARD CERTIFICATE OF DEATH

Registrar's No. 28

1 PLACE OF DEATH: (County) Worcester; (City or Town) Fayville; No. (Woodlawn) Road - Woodland Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emma (Brodeur) Collette (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Woodlawn Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Collette (Give maiden name of wife here.) (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 82 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: At Home

10 Industry or Business: At Home

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) St Catharines Ont Canada

PARENTS

13 NAME OF FATHER Hippolyte Brodeur

14 BIRTHPLACE OF FATHER (City) (State or country) Lyn Canada

15 MAIDEN NAME OF MOTHER Elsa Labarre

16 BIRTHPLACE OF MOTHER (City) (State or country) Lyn Canada

17 Informant Mr Louis Collette (Address) Woodlawn Road Fayville Mass Relation, if any Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tuttle (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Dec 16 1946 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December 16 1946 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct 30, 1946 to Dec. 16, 1946

I last saw her alive on Dec 15, 1946, death is said to have occurred on the date stated above, at 6:45 A.M.

Immediate cause of death: Chronic myocarditis and myocardial degeneration — Duration IMPORTANT: several years

Due to arteriosclerosis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Date of

Of autopsy

What test confirmed diagnosis?

IMPORTANT

Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John K. Ruggles Jr., M. D.

(Address) Hopkinton Mass Date Dec 16 1946

21 Place of Burial, Cremation or Removal: Rural Cemetery Southboro Mass (City or Town)

DATE OF BURIAL Dec 18 1946

22 NAME OF FUNERAL DIRECTOR Flessen & Ledoux

ADDRESS 451 Lincoln St Marlboro Mass

Received and filed Dec 18 1946

John J. Rahemi (Registrar)

A TRUE COPY ATTEST:

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(d)-3-43-11574

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No. 27

1 PLACE OF DEATH: Worcester (County) — Fayville (City or Town) — No. 1 Pleasant St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Joseph Baldelli (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Pleasant St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Victoria Mandrigrini (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive 64 years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Caretaker

10 Industry or Business: Retired

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Sant'Angelo Italy

PARENTS

13 NAME OF FATHER Dominic Baldelli

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER Unknown

16 BIRTHPLACE OF MOTHER (City) (State or country) Unknown

17 Informant Mr Louis Belisle (Address) Pleasant St Fayville (Relation, if any) Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Dwyer (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Dec 23-46 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December (Month) 21 (Day) 1946 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1946, to Dec 21, 1946

I last saw him alive on December 21, 1946, death is said to have occurred on the date stated above, at 4.40 P.M.

Immediate cause of death — Duration IMPORTANT

Coronary Thrombosis — 2 Days
Due to Arteriosclerosis — 7 yrs.

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations — Date of

Of autopsy

What test confirmed diagnosis? Ordinary

IMPORTANT

Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Peter P. Cottone, M. D.
(Address) 25 W. Main St. Date Dec 23 1946

21 Rural Cemetery South Grafton
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec 24 1946

22 NAME OF FUNERAL DIRECTOR Blodgett & Lebeau
ADDRESS 45 Randolph St Worcester Mass

Received and filed December 31 1946
Frances E Lebeau (Registrar)

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. #1

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town)

No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John F. McHugh (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Parkerville Rd. St. Southborough (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): married

5a If married, widowed, or divorced HUSBAND of Katherine Doyle (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 86 years

7 IF STILLBORN, enter that fact here.

8 AGE 82 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: editor

10 Industry or Business: newspaper

11 Social Security No. 032-01-3960

12 BIRTHPLACE (City) (State or country) Dublin Ireland

PARENTS

13 NAME OF FATHER: Arthur McHugh

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Anne Duffy

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address): Edward H. McHugh (brother) Parkerville Rd Southboro

A TRUE COPY. ATTEST: J. J. Bertrand (Registrar of city or town where death occurred)

DATE FILED Jan 5 1947

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Jan 4 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1946 to Jan 4, 1947

I last saw him alive on Jan 3, 1947, death is said to have occurred on the date stated above, at 2.45 A.M.

Immediate cause of death — Duration

Hypertrophied prostate

surgical shock 1 dy

Due to

Due to

Other conditions prostatectomy 1 dy (Include pregnancy within 3 months of death)

Major findings: Of operations

Date of Of autopsy as above 1-3-47

What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Albert E. LeMarbre, M. D.

(Address) Marlborough Date 1-4-1947

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cemetery Southbo (Cemetery) (City or Town)

DATE OF BURIAL Jan 7 1947

22 NAME OF FUNERAL DIRECTOR John P. Rowe

ADDRESS 57 Main St. City

Received and filed January 30 1947

Lucas E Kahrs (Registrar of City or Town where deceased resided)

M R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. ACE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 2

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Main St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Marie Elisabeth Herminie (Bouthillet) Fairbanks (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community 60 years ..... months ..... days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF Charles F. Fairbanks
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 83 Years 0 Months 1 Days | If less than 1 day Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Bozel Canada

PARENTS

13 NAME OF FATHER Ulderic Bouthillet

14 BIRTHPLACE OF FATHER (City) (State or country) Contre Coeur Canada

15 MAIDEN NAME OF MOTHER Caroline Lamere

16 BIRTHPLACE OF MOTHER (City) (State or country) Canada

17 Informant (Address) Gladys Nichols Middle Rd., Southboro — Relation, if any (Daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agent
(Official Designation)

Jan. 47
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January (Month) 7 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from January 2, 1947, to January 7, 1947

I last saw h alive on January 7, 1947, death is said to have occurred on the date stated above, at 2.45 P.M.

Immediate cause of death: Carcinoma of ovary (Rt). — Duration Important: 3 yrs.

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) — Important

Major findings: Of operations ..... Date of .....

Of autopsy .....

What test confirmed diagnosis? Physical examination

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No.

If so, specify .....

(Signed) Peter P. Cottone M.D.

(Address) 75 W. Main St. Date Jan 7 1947

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL January 10, 1947

22 NAME OF FUNERAL DIRECTOR Quimby & Gage

ADDRESS 15 Cottin Ave. Marlboro

Received and filed January 10 1947

John J. Rabeni
(Registrar)

A TRUE COPY ATTEST:

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 3

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dennis F McCarthy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Oak St
(Usual place of abode)

(If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community ..... yrs. ..... mos. 4 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 61 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Watchman

10 Industry or Business: N.Y.N.H.&H. Railroad Co

11 Social Security No. 706-03-9592

12 BIRTHPLACE (City) (State or country): Marlboro Mass

PARENTS

13 NAME OF FATHER: Daniel McCarthy

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Catherine Lyons

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant (Address): Mrs. Dora McCarthy 59 Park St. Hudson Mass (Relation, if any): Niece

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F Fetter
(Signature of Agent of Board of Health or other)
Burial Agent
(Official Designation)
Jan. 17-47
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Jan (Month) 16 (Day) 1947 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Cancer of pancreas and liver

20 Accident, suicide, or homicide (specify) .....
Date of occurrence ..... 19 .....
Where did Injury occur? ..... (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)
Manner of Injury .....
Nature of Injury .....
While at work? ..... Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Walter F Mahoney, M. D.
(Address) Westboro Date Jan 16 1947

22 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Jan 18 1947

23 NAME OF FUNERAL DIRECTOR John J Brown
ADDRESS 93 Main St Marlboro

Received and filed January 18 1947
Frances E Lahaise
asst clerk (Registrar)

FORM R-301 A

N.B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

Sent to Worcester

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 4

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Boston Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Mary (Sharry) Long (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 23 Courtland St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ____ years ____ months ____ days. (Before death) (Specify whether) In this community ____ yrs. ____ mos. ____ days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
female	white	widowed

5a If married, widowed or divorced
HUSBAND of ____ (Give maiden name of wife in full)
(or) WIFE of Thomas Long (Husband's name in full)

6 Age of husband or wife if alive ____ years

7 IF STILLBORN, enter that fact here.

8 AGE 59 Years ____ Months ____ Days | If less than 1 day ____ Hours ____ Minutes

9 Usual Occupation: housewife

10 Industry or Business: ____

11 Social Security No. ____

12 BIRTHPLACE (City) (State or Country) Ireland

PARENTS

13 NAME OF FATHER: Thomas Sharry

14 BIRTHPLACE OF FATHER (City) (State or Country): Ireland

15 MAIDEN NAME OF MOTHER: ~~woodbourn~~ O'Keefe

16 BIRTHPLACE OF MOTHER (City) (State or Country): Ireland

17 Informant (Address): Rev. Pat. E. Long, Boston Rd. Southboro (Relation, if any): son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Foley (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Jan. 29, 1947 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Jan (Month) 29 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 1, 1946, to Jan 29, 1947

I last saw her alive on Jan 28, 1947, death is said to have occurred on the date stated above, at 4.00 P. m.

Immediate cause of death: Cortico Sclerosis — Duration: 10 yrs

Due to: Senility

Due to: ____

Other conditions (Include pregnancy within 3 months of death): ____

Major findings: Of operations: ____ Date of: ____

Of autopsy: ____

What test confirmed diagnosis? Physical findings

IMPORTANT — Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify ____

(Signed) William J. McCarthy, M. D.

(Address) 126 Main St Date 1/30 1947

21 St. John's Worcester (Place of Burial, Cremation or Removal) (City or Town)

DATE OF BURIAL Jan 31 1947

22 NAME OF FUNERAL DIRECTOR: John J. Fay

ADDRESS 7 Woodland St.

Received and Filed Feb. 5 1947

John J. Rabemi (Registrar)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 5

1 PLACE OF DEATH: Worcester (County); Fayville (City or Town); No. 80 Central St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: John J. Richard (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Central St. Fayville Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months days. In this community 2 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed or divorced HUSBAND of Agnes Gaudet. (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE 81 Years 1 Months 5 Days | If less than 1 day ... Hours ... Minutes

9 Usual Occupation: Shoe Worker (Retired)

10 Industry or Business: Exeter, N.H. Shoe Shops.

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Prince Edward Island

PARENTS

13 NAME OF FATHER: John H. Richard

14 BIRTHPLACE OF FATHER (City) (State or country) Prince Edward Island

15 MAIDEN NAME OF MOTHER: Mary Rose Gallant

16 BIRTHPLACE OF MOTHER (City) (State or country) Prince Edward Island

17 Informant (Address) Mrs. Frances P. Willard 80 Central St. Fayville Mass. Relation, if any. Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Leeks (Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) Feb 4. 1947 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Feb (Month) 3 (Day) 1947 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Asphyxiation - Suffocation
Shocked to death

20 Accident, suicide, or homicide (specify) Accident

Date of occurrence Feb 3 1947

Where did Injury occur? Fayville Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Farm (Specify type of place)

Manner of Injury: Burning over a brush & land

Nature of Injury: Asphyxiation - Suffocation - burns

While at work? yes Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date Feb 3 1947

22 Exeter Cemetery. Exeter, N. H. Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL February 6. 1947

23 NAME OF FUNERAL DIRECTOR: L. D. Leeskow

ADDRESS Framingham Mass

Received and filed Feb. 5 1947 19

John J. Rabeno (Registrar)

RM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 6

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Baker Rest Home St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Wesleyetta F. (Chickering) Collins
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Tatisquama Road St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 2 years ..... months ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF Hiram D. Collins
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years 6 Months 27 Days | If less than 1 day Hours ..... Minutes

9 Usual Occupation: Retired housewife

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Boston Mass

PARENTS

13 NAME OF FATHER John W Chickering

14 BIRTHPLACE OF FATHER (City) (State or country) Portland Maine

15 MAIDEN NAME OF MOTHER Abbie E. Brown

16 BIRTHPLACE OF MOTHER (City) (State or country) Kennebunk Maine

17 Informant Old Pension Records Relation, if any .....
(Address) Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tufts
(Signature of Agent of Board of Health or other)

Burial Agent
(Official Designation)

Feb 23 1947
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH February (Month) 22 (Day) 1947. (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1947, to Feb 22, 1947

I last saw her alive on Feb 20, 1947, death is said to have occurred on the date stated above, at 2:00 A.M.

Immediate cause of death	Duration Important
Chronic myocarditis	5 yrs.
Due to generalized arteriosclerosis	20 yrs
Due to	
Other conditions (Include pregnancy within 3 months of death)	Important
Major findings: Of operations	Physician
Date of	Underline the cause to which death should be charged statistically.
Of autopsy	
What test confirmed diagnosis?	

20 Was disease or injury in any way related to occupation of deceased? No.
If so, specify .....

(Signed) Allan P. Roog M.D.
(Address) 230 Main St Southboro Mass. Date Feb 22 1947

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Feb 25, 1947

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS 15 Cotting Ave., Marlboro

Received and filed February 27 1947
James E. Laherin
(Registrar)

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 97 6A

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town); No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Annie Frances Byard (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Foxcroft Farm St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months days. In this community 1 yrs. 1 mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of John L. Byard (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE 87 Years Months 17 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Peru Vermont

PARENTS

13 NAME OF FATHER: Elijah Simonds

14 BIRTHPLACE OF FATHER (City) (State or country) Peru Vermont

15 MAIDEN NAME OF MOTHER: Angie Eddy

16 BIRTHPLACE OF MOTHER (City) (State or country) Winhall Vermont

17 Informant: Mrs. Parker Uhlman (Relation, if any) (daughter)
(Address) E. Main St. Westboro

A TRUE COPY. ATTEST: Annie A. Dunne
(Registrar of city or town where death occurred)

DATE FILED April 3 1947

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: April 3, 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 27, 1944, to April 3, 1947

I last saw her alive on April 2 1947, death is said to have occurred on the date stated above, at 3.30 a. m.

	Duration
Immediate cause of death: myocarditis chronic	?
Due to arterio sclerosis chro	?
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations none Date of

Of autopsy no

What test confirmed diagnosis? Physical exam

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Roland S. Newton, M. D.

(Address) Westboro, Mass. Date Apr. 3 1947

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Rural (Cemetery) Southboro (City or Town)

DATE OF BURIAL April 5, 1947

22 NAME OF FUNERAL DIRECTOR: Sumner C. Gage

ADDRESS: 15 Cotting Ave. Marlboro

Received and filed May 12 1947

Frances E. Dolan Town Clerk
(Registrar of City or Town where deceased resided)

ORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 45, Section 10, requires physicians to insert a recital to that effect.

100m(j)-1-44-13634

Worcester

Sent to Northboro

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 7

1 PLACE OF DEATH: (County) Middlesex; (City or Town) Southboro; No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Minnie Aurelia Cranesee
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. ..... St. Northboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) Institution / years 3 months 6 days. In this community yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 80 Years 4 Months 19 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: None

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

13 NAME OF FATHER: Albert Crowell

14 BIRTHPLACE OF FATHER (City) (State or country): Yarmouth Mass

15 MAIDEN NAME OF MOTHER: Irene Crowell

16 BIRTHPLACE OF MOTHER (City) (State or country): Yarmouth Mass

17 Informant (Address) Boards of Public Welfare Northboro Relation, if any

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Fuller
(Signature of Agent of Board of Health or other)

Burial Agent (Official Designation) April 14. 1947 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 13 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1945, to April 13, 1947

I last saw h[illegible] alive on April 12, 1947, death is said to have occurred on the date stated above, at 2:50 A. m.

	Duration
Immediate cause of death	IMPORTANT
Chronic myocarditis	10 yrs.
Due to	
generalized arteriosclerosis	15 yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	IMPORTANT

Major findings: Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No.
If so, specify .....
(Signed) Ellen P. Rice, M. D.
(Address) 170 Main St Northboro Date 13 Apr 1947

21 Harold A. Spaulding Northboro, Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 15 1947

22 NAME OF FUNERAL DIRECTOR E. Standish Stubbs
ADDRESS 9 Pleasant St Northboro, Mass.

Received and filed April 16 1947
Frances E Roberts
(Registrar)

FORM R-301

M. E.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

50m-(d)-3-43-11574

Sent to vital

(City or town making return)

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registrar's No. 8

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town) No. Commons Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Ellen Hayes (If deceased is a married, widowed or divorced woman, give also maiden name)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 77 Huntington Ave St. Marlboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 86 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housekeeper

10 Industry or Business: Retired

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Maynard Mass

PARENTS

13 NAME OF FATHER Edmond Hayes

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Ellen Moynahan

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant Lee Hayes (Relation if any)
(Address) 13 Edmund Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Tefft
(Signature of Agent of Board of Health or other)

Burial Agent. April 18. 47
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Apr (Month) 17 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1947, to Apr 17, 1947

I last saw h alive on Apr 16, 1947, death is said to have occurred on the date stated above, at 2.00 P.M.

Immediate cause of death: Coronary occlusion — Duration IMPORTANT: 5 min

Due to: Arterio Sclerosis

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: none — Date of:

Of autopsy: no

What test confirmed diagnosis? Examination

IMPORTANT — Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) C. W. Smith, M. D.
(Address) Marlboro Date 4/18 1947

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Apr 22 1947

22 NAME OF FUNERAL DIRECTOR John F. Sorey
ADDRESS 75 W. Main St. Marlboro

Received and filed Apr 22 1947

James E. Tefft
(Registrar)

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. .....

1 PLACE OF DEATH

Middlesex
(County)

Framingham
(City or Town)

No. 25 Oliver St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charlotte Lincoln McMaster
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 25 Oliver St. St. Framingham
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years .....months .....days. In place of residence .....years 6 months .....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 18, 1947
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1946 to April 18, 1947

I last saw her alive on April 18 47, death is said to have occurred on the date stated above, at 6:30 A.M.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma left ovary	
ANTECEDENT CAUSES Due To (b) Metastases to liver & lungs	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations Generalized cancer of whole pelvis

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) A.A. Matarese M. D.

(Address) Framingham, Mass. Date 4/18/47 19

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 20, 1947 19

7 NAME OF FUNERAL DIRECTOR Frederick A. Cookson

ADDRESS 318 Union Ave., Framingham

Received and filed May 3 / 19 47

Frances E Raham
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Harry A. McMaster
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 1 Months 13 Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Gardner, Col.
(State or country)

PARENTS

17 NAME OF FATHER Richard M. Lincoln

18 BIRTHPLACE OF FATHER (City) Boston, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Mabel V. Murray

20 BIRTHPLACE OF MOTHER (City) Springfield, Mo.
(State or country)

21 Informant Mrs. E. Warren Ward
(Address) 25 Oliver St., Framingham

A TRUE COPY
ATTEST: Wm J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED April 21, 1947 19

ORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's Number 9

1 PLACE OF DEATH: (County) Worcester; (City or Town) Fayville; No. Turnpike Rd St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Catherine Smiddy (nee Eagan)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 47 years ..... months ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Married

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF William Smiddy
(Husband's name in full)

6 Age of husband or wife if alive 76 years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years ..... Months ..... Days | If less than 1 day Hours ..... Minutes

9 Usual Occupation: At Home

10 Industry or Business: —

11 Social Security No. —

12 BIRTHPLACE (City) (State or country) Framingham Mass

PARENTS

13 NAME OF FATHER Owen Eagan

14 BIRTHPLACE OF FATHER (City) (State or country) N. Y. City

15 MAIDEN NAME OF MOTHER Ellen Heffron

16 BIRTHPLACE OF MOTHER (City) (State or country) can not be learned

17 Informant (Address) Earl R Smiddy Turnpike Rd Fayville Relation, if any Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feller
(Signature of Agent of Board of Health or other)
Burial Agent April 20-47
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 19, (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1947, to Apr 19, 1947
I last saw her alive on Apr. 15, 1947, death is said to have occurred on the date stated above, at 4.30 P.M.

Immediate cause of death ..... Duration Important
Carcinoma of stomach 6 mos.
Due to .....
Due to .....
Other conditions (Include pregnancy within 3 months of death) Important
Major findings: Of operations .....
Date of .....
Of autopsy .....
What test confirmed diagnosis? X Ray & Judges

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) William J. DeLaney M.D.
(Address) 186 Main St Date 4/19 47

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 22 1947

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed April 22 1947
Frances E Roberts
(Registrar)

A TRUE COPY ATTEST:

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m (d)-1-41-4067

Sent to Soy

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 10

1 PLACE OF DEATH: ~~Middlesex~~ Worcester (County) — Southville (City or Town) — No. Southville Ave. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Mary Jane Reid (If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence, No. Water Street (Usual place of abode) St. Saxonville, Mass. (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. (Before death) (Specify whether) In this community yrs. mos. 7 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of Peter Reid (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 72 Years 8 Months 15 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: ~~Housewife~~

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Scotland

PARENTS

13 NAME OF FATHER Lawrence Turpie

14 BIRTHPLACE OF FATHER (City) (State or country) Scotland

15 MAIDEN NAME OF MOTHER C N B L

16 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

17 Informant Robert L. Reid (Address) Southville Rd., Southville, Relation, if any (Son)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Keefe
(Signature of Agent of Board of Health or other)
Burial Agent. May 21 1947
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May (Month) 20 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 10, 1947, to May 14, 1947

I last saw h.er alive on May 14, 1947, death is said to have occurred on the date stated above, at 7:00 A m.

Immediate cause of death ..... Duration IMPORTANT
Acute coronary occlusion
Due to Arterio-sclerotic + Hypertensive Heart Disease.
Due to .....
Other conditions (Include pregnancy within 3 months of death) IMPORTANT
Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) Wilbert M. Peterson, M. D.
(Address) 25 Lincoln St. Date May 20 1947

21 Place of Burial, Cremation or Removal. Edwards Cemetery Saxonville, Mass.
DATE OF BURIAL May 22, 1947

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS 318 Union Ave. Framingham

Received and filed May 27 1947
Frances E Roberts
(Registrar)
asst clerk

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD
CERTIFICATE OF DEATH

(City or town making return)

Registered No. 11

1 PLACE OF DEATH
Worcester (County)
Southborough (City or Town)
No. Southville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Rosella Coyle Welch (Coyle)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(If U. S. War Veteran, specify WAR)

(a) Residence. No. Southville Road St. Cordaville in Southboro
(Usual place of abode) (If nonresident, give city or town and state)
Length of stay: In hospital or institution .... years months days. In this community 77 yrs. 6 mos. 24 days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of John Edward Welch (Husband's name in full)

6 Age of husband or wife if alive .... years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years 7 Months 17 Days. If less than 1 day ... Hours ... Minutes

9 Usual Occupation: housewife

10 Industry or Business: home

11 Social Security No.

12 BIRTHPLACE (City) Milford (State or country) Mass

PARENTS

13 NAME OF FATHER: Peter Coyle

14 BIRTHPLACE OF FATHER (City) unascertainable (State or country) Ireland

15 MAIDEN NAME OF MOTHER: Margaret Kennedy

16 BIRTHPLACE OF MOTHER (City) unascertainable (State or country) Ireland

17 Informant: Margaret Welch. Relation, if any: (daughter)
(Address) Cordaville Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Rosamelia Hall Beasley
(Signature of Agent of Board of Health or other)

Clerk (Official Designation)

June 21-47 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: June (Month) 21 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1936, to June 21, 1947
I last saw her alive on June 21, 1947, death is said to have occurred on the date stated above, at 3.55 p.m.

	Duration
Immediate cause of death: Myocarditis Chronic	10 yrs.
Due to Arterio Sclerosis Chronic	-3-
Due to	
Other conditions: Acute gastro enteritis: June 16 to 19-1947 (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Cholelithiasis - Intestinal obstruction. Date of 19
Of autopsy: none
What test confirmed diagnosis? History - Physical exam

PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify.

(Signed) Roland A. Nenton M. D.
(Address) Westboro. Date June 21 1947

21 St. John's Hopkinton
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL June 24 1947

22 NAME OF FUNERAL DIRECTOR: T. F. Callanan & Son
ADDRESS: Hopkinton, Mass.

Received and filed July 14 1947

Frances E Raleu (Registrar)

A TRUE COPY ATTEST:

100m-10-'39. No. 8417-d

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

30m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 145

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town); No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number) 18

2 FULL NAME Jennie L. Ramsdell (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. ... St. Southville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ... years ... months 11 days. In this community ... yrs. ... mos. ... days. (Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	white	married

5a If married, widowed, or divorced
HUSBAND of ...
(or) WIFE of Edward C. Ramsdell (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive 81 years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years 3 Months 27 Days | If less than 1 day ... Hours ... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: ...

11 Social Security No. ...

12 BIRTHPLACE (City) (State or country) China, Maine

PARENTS

13 NAME OF FATHER: William Hammond

14 BIRTHPLACE OF FATHER (City) (State or country) China, Maine

15 MAIDEN NAME OF MOTHER: Unable to obtain

16 BIRTHPLACE OF MOTHER (City) (State or country) Maine

17 Informant State Hospital records (Address) (Relation, if any)

A TRUE COPY. ATTEST: Bernice A. Dunne (Registrar of city or town where death occurred)

DATE FILED June 30, 1947

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June 23, 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 12, 1947, to June 23, 1947

I last saw her alive on June 23, 1947 death is said to have occurred on the date stated above, at 2:5 p. m.

	Duration
Immediate cause of death: Bronchial pneumonia	12 hrs.
Due to: General arteriosclerosis	years
Due to: chronic myocarditis	?
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations ... Date of ... Of autopsy ...

What test confirmed diagnosis? clinical

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify ...

(Signed) Margaret Hatfield, M. D.

(Address) Westboro, Mass. Date 6/23 1947

21 PLACE OF BURIAL, CREMATION OR REMOVAL Dell Park, Natick, Mass (Cemetery) (City or Town)

DATE OF BURIAL June 26 1947

22 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed July 16 1947

Bernice A. Dunne (Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 13

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lucia (Pascucci) Riccio (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Turnpike Rd. St. Southboro, Mass. (If nonresident, give city or town and state)
(Usual place of abode)

Length of stay: In hospital or institution Hospital (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Frank Riccio (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 93 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At Home

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Italy

PARENTS

13 NAME OF FATHER Joseph Pascucci

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER Unobtainable

16 BIRTHPLACE OF MOTHER (City) (State or country) Unobtainable

17 Informant Michael Riccio (Son) Relation, if any
(Address) Turnpike Rd., Southboro, Mass.

A TRUE COPY.
ATTEST: W. F. Walsh
(Registrar of city or town where death occurred)
DATE FILED July 1, 1947 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June 30, 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 9, 1947, to June 30, 1947
I last saw her alive on June 29, 1947, death is said to have occurred on the date stated above, at 4:45 A.M.

Immediate cause of death	Duration
Cerebral accident	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death) Obstructing Duodenal Ulcer	

Major findings:
Of operations None
Date of
Of autopsy None
What test confirmed diagnosis? Clinical Ex.

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) C. W. Howe, M. D.
(Address) Framingham, Mass. Date 6/30 19 47

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cem. (Cemetery) Southboro, Mass. (City or Town)
DATE OF BURIAL July 2 19 47

22 NAME OF FUNERAL DIRECTOR John P. Rowe
ADDRESS Marlboro, Mass.

Received and filed July 7 19 47
Frances E. Palmeri
(Registrar of City or Town where deceased resided)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

50m-(d)-3-43-11574

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No. 14

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Newton St. Boyd — St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Daniel Starks Brookins (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) —

(a) Residence. No. Newton St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Ella Mc. Guest (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 67 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation:

10 Industry or Business: Wenford Dairy

11 Social Security No. 024-05-2023

12 BIRTHPLACE (City) (State or country) Ipswich Mass

PARENTS

13 NAME OF FATHER Jacob Starks

14 BIRTHPLACE OF FATHER (City) (State or country) Ipswich Mass

15 MAIDEN NAME OF MOTHER Mary Lord

16 BIRTHPLACE OF MOTHER (City) (State or country) Ipswich Mass

17 Informant (Address) Mrs Ella Mc Guest Newton St Southboro — Relation, if any Brother

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Rebecca Hall Boston RN (Signature of Agent of Board of Health or other)

Clerk (Official Designation)

July 9 1947 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: July (Month) 8 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from April 11, 1943, to July 8, 1947

I last saw him alive on July 7, 1947, death is said to have occurred on the date stated above, at 6 a.m. M.

	Duration IMPORTANT
Immediate cause of death: Coronary Occlusion	4 days
Due to: Arteriosclerosis	5 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death): Cerebral Thrombosis	4 yrs

IMPORTANT — Physician — Underline the cause to which death should be charged statistically.

Major findings: Of operations — Date of — Of autopsy — What test confirmed diagnosis?

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Hans F Braun, M. D.
(Address) Framingham Date July 9 1947

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 10, 1947

22 NAME OF FUNERAL DIRECTOR John J Burns
ADDRESS 75 Main St Marlboro

Received and filed July 14 1947
Frances E Nabeus (Registrar)

A TRUE COPY ATTEST:

FORM R-301 A

N.B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Middle Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edith (Cunningham) Forsythe
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Middle Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months days. In this community yrs. 2 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Married

5a If married, widowed or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of William E. Forsythe
(Husband's name in full)

6 Age of husband or wife if alive 79 years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years 10 Months 29 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: Own Home

11 Social Security No. None

12 BIRTHPLACE (City) Harrington (State or Country) Maine

PARENTS

13 NAME OF FATHER Michael Cunningham

14 BIRTHPLACE OF FATHER (City) (State or Country) Maine

15 MAIDEN NAME OF MOTHER Mathilda Grant

16 BIRTHPLACE OF MOTHER (City) (State or Country) Maine

17 Informant (Address) Mrs John Parker Daughter In Law (Relation, if any)
Middle Road Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

Rowena Hall Boston RN
(Signature of Agent of Board of Health or other)

Clerk
(Official Designation)

July 11-1947
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 11, 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from April, 1947, to July, 1947

I last saw her alive on 9 July, 1947, death is said to have occurred on the date stated above, at 10:30 A.m.

	Duration
Immediate cause of death: Congestive Failure	IMPORTANT 2 mos.
Due to: Arteriosclerosis, generalized	2 yrs
Due to: Diabetes mellitus and Senility	several yrs
Other conditions — (Include pregnancy within 3 months of death)	

IMPORTANT

Physician — Underline the cause to which death should be charged statistically.

Major findings: Of operations — Date of —

Of autopsy —

What test confirmed diagnosis? —

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Timothy P. Horne, M. D.
(Address) Southboro, Mass. Date 11 July, 1947

21 Woodlawn Clinton
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 14, 1947

22 NAME OF FUNERAL DIRECTOR Walter E. Stone
ADDRESS 63 Prospect St. Clinton, Mass.

Received and Filed July 14 1947
Frances E. Rakeman
(Registrar)

FORM R-301 A

N.B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro

No. Latisquama Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mabel E. Evans (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Oak St. (Usual place of abode) (If nonresident, give city or town and State) Ashland

Length of stay: In hospital or institution (Before death) Rest Home (Specify whether) 2 years months days. In this community — yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (Give maiden name of wife in full)

(or) WIFE of William H. Evans (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 68 Years 5 Months 4 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: Iron Foundry

11 Social Security No. None

12 BIRTHPLACE (City) Cambridge (State or Country) Mass.

PARENTS

13 NAME OF FATHER: Samuel N. Bailey

14 BIRTHPLACE OF FATHER (City) Cambridge (State or Country) Mass.

15 MAIDEN NAME OF MOTHER: Frances Furbish

16 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or Country) Maine

17 Informant: George B. Evans (Address) Oak St, Ashland, Mass. (Relation, if any) Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James H. Miller - Mgr. (Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) July 26, 1947

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: July (Month) 25 (Day) 47 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 2, 1947, to July 25, 1947

I last saw her alive on July 25, 1947, death is said to have occurred on the date stated above, at 9.30 A m.

Immediate cause of death: Chronic Myocarditis. — Duration IMPORTANT: 2 yrs

Due to: Arteriosclerotic Heart disease — ?

Due to: —

Other conditions: Tuberculosis? (Include pregnancy within 3 months of death) — ?

Major findings: Of operations — Date of —

Of autopsy —

What test confirmed diagnosis?

IMPORTANT — Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) F. J. Cunningham M. D.

(Address) Ashland Mass. Date July 26 1947

21 Central Cemetery Worcester, Mass. Place of Burial, Cremation or Removal (City or Town)

DATE OF BURIAL July 29, 1947

22 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 60 E. Main St, Marlboro Mass.

Received and Filed Aug 7 1947

Frances E. Roberts (Registrar)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m (d)-1-41-4667

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 17

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. West Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Victor Carl Bushman
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. West Main St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community 10 yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of Esther Little
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 55 Years 9 Months 14 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Chemical Broker

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Hamburg, Germany

PARENTS

13 NAME OF FATHER Frederick Bushman

14 BIRTHPLACE OF FATHER (City) (State or country) Germany

15 MAIDEN NAME OF MOTHER Caroline Kruger

16 BIRTHPLACE OF MOTHER (City) (State or country) Germany

17 Informant Esther Bushman (Relation, if any wife)
(Address) W. Main St., Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James H. Walker - D.M.C.
(Signature of Agent of Board of Health or other)

(Official Designation) July 31, 1947 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 29 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from May 30 1947, to July 29, 1947

I last saw h... alive on July 29, 1947, death is said to have occurred on the date stated above, at 7.45 P m.

	Duration IMPORTANT
Immediate cause of death	
Cancer of the liver	8 mos
Due to (origin undetermined)	
Due to	
Other conditions (Include pregnancy within 3 months of death)	IMPORTANT
Major findings: Of operations ..... Date of	Physician Underline the cause to which death should be charged statistically.
Of autopsy	
What test confirmed diagnosis? Biopsy	

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify .....

(Signed) Hugh F. Keane, M. D.
(Address) Framingham Date July 31 1947

21 Place of Burial, Cremation or Removal. High Street, Hingham, Mass. (City or Town)
DATE OF BURIAL August 1, 1947

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS Framingham, Mass.

Received and filed August 7 1947
Charles E. Roberts (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 18

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. Gilmore Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice Day Heath
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Garrison House Gilmore Road St. Southville Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months days. In this community 2 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Married

5a If married, widowed or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Alexander Heath
(Husband's name in full)

6 Age of husband or wife if alive 84 years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years 4 Months 5 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business:

11 Social Security No. None

12 BIRTHPLACE (City) (State or Country) Chelsea, Mass.

PARENTS

13 NAME OF FATHER John Warner Day

14 BIRTHPLACE OF FATHER (City) (State or Country) Gloucester, Mass.

15 MAIDEN NAME OF MOTHER Abby Alice Chamberlin Pinckney

16 BIRTHPLACE OF MOTHER (City) (State or Country) Boston, Mass.

17 Informant (Address) Ann Heath Cram (Relation, if any) (Daughter)
Southville Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

(Signature of Agent of Board of Health or other)

(Official Designation) (Date of Issue of Permit) 9/8/47

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Sept (Month) 5 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1945, to Sept 5, 1947

I last saw her alive on Sept 3, 1947, death is said to have occurred on the date stated above, at 3:15 P m.

Immediate cause of death — Duration
Cerebral Thrombosis — 2 days
Due to Generalized arteriosclerosis + Hypertension — 10 yrs +
Due to
Other conditions Bilateral leg amputation for A-Sacgangrene
(Include pregnancy within 3 months of death)

IMPORTANT

Major findings: Of operations — Date of
Of autopsy
What test confirmed diagnosis?

IMPORTANT
Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Hugh Folsom, M. D.
(Address) 198 Grafton Ave Date Sept 6 1947

21 Rural Cemetery Southboro, Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Monday September 8, 1947

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS 318 Union Ave. Framingham, Mass

Received and Filed September 10 1947
Frances E Palmeri
(Registrar)

RM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 19

1 PLACE OF DEATH
(County) Worcester
(City or Town) Southboro
No. Baker Rest Home Latisquama Rd St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Mary A Dunn
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 29 Bridge St St. Marlboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Rest Home years 2 months days. In this community years months days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 79 Years ... Months ... Days | If less than 1 day ... Hours ... Minutes

9 Usual Occupation: at Home

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

13 NAME OF FATHER Michael Dunn

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Margaret Carey

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant Margaret Steward Relation, if any (Sister)
(Address) 29 Bridge St Marlboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Nelker
(Signature of Agent of Board of Health or other)

(Official Designation) 9/18/47 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Sept. 17 1947
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from June, 1946 to Sept 16, 1947
I last saw h[er] alive on Sept 16, 1947 death is said to have occurred on the date stated above, at 3 [illegible] P.M.

Immediate cause of death
Chronic Myocarditis — Duration Important: 1 yr.
Due to
Due to Arterial Sclerosis & Hypertension — 1 yr.
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations none — Date of
Of autopsy none
What test confirmed diagnosis? Physical Signs

Important — Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) John F. Collins M.D.
(Address) Marlboro Mass Date Sept 18 1947

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Sept 20 1947

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed September 20 1947
Frances E Roberts
(Registrar)

A TRUE COPY ATTEST:

FORM R-305

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-10-39. No. 8427-g

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No.

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Henry Sangervasi (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) 20

(a) Residence. No. Cordaville Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution Hospital (Specify whether) years months 7 days. In this community 16 yrs. 1 mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Edith Sanchioni (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 45 years

7 IF STILLBORN, enter that fact here.

8 AGE 46 Years 1 Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Millwright

10 Industry or Business: Telechron, Inc.

11 Social Security No. 021-05-0603

12 BIRTHPLACE (City) Italy (State or country)

PARENTS

13 NAME OF FATHER Alexander Sangervasi

14 BIRTHPLACE OF FATHER (City) Italy (State or country)

15 MAIDEN NAME OF MOTHER Anna Faccini

16 BIRTHPLACE OF MOTHER (City) Italy (State or country)

17 Informant (Address) Mrs. Edith Sangervasi wife (Relation, if any) Cordaville Rd., Southboro

A TRUE COPY. ATTEST: Wm. J. Walsh (Registrar of city or town where death occurred)

DATE FILED December 1, 1947

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH October 14, 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

"Stem cell" Aleukemic Leukemia

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did Injury occur? (City or town and State)

Did injury occur in or about the home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury

Nature of Injury

While at work? Was there an autopsy? yes

21 Was disease or injury in any way related to occupation of deceased? not certain.
If so, specify Alleged industrial accident.
(Signed) J. H. McCann, M. D.
(Address) Framingham, Mass. Date 12/1/47 19

22 Rural Cemetery Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL October 17, 1947 19

23 NAME OF FUNERAL DIRECTOR Eugene J. McCarthy
ADDRESS 11 Lincoln St., Framingham

Received and filed Oct 23 19 47
(Registrar of City or Town where deceased resided)

19A

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

25M-(f)-11-42 10746

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

NEWTON (City or town making return)

Registered No. 561

1 PLACE OF DEATH: (County) MIDDLESEX; (City or Town) NEWTON; No. Newton-Wellesley Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Boy Brown (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) 21

(a) Residence. No. McVickery Rd. St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years (Specify whether) months 4 days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE Years Months 4 Days | If less than 1 day Hours Minutes

9 Usual Occupation:

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) Newton (State or country) Mass.

PARENTS

13 NAME OF FATHER Robinson Brown

14 BIRTHPLACE OF FATHER (City) Shelburne (State or country) Mass.

15 MAIDEN NAME OF MOTHER Barbara Douglas

16 BIRTHPLACE OF MOTHER (City) Stowe (State or country) Vermont

17 Informant Robinson Brown (Relation, if any Father)
(Address) McVickery Rd, Southboro

A TRUE COPY.
ATTEST: Frank Mahant
(Registrar of city or town where death occurred)

DATE FILED October 22, 1947

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Oct 20, 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from 10/17/47, 19..., to 10/20/47, 19...
I last saw him alive on 10/20/47, 19..., death is said to have occurred on the date stated above, at 11:55A. m.

Duration

Immediate cause of death: Circulatory Failure

Due to Encephalopathy and Pulmonary Atalectasis — 3 days

Due to Neonatal asphyxia

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations... Date of...

Of autopsy...

What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify...

(Signed) John K. Brines M. D.
(Address) 611 Washington St, Wellesley Date 10/20/47 19...

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cemetery, (Cemetery) Southboro (City or Town)
DATE OF BURIAL October 21, 1947 19...

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS 15 Cotting Ave., Marlboro

Received and filed November 13 1947
Frances E Roberts
(Registrar of City or Town where deceased resided)

FORM R-301 A

N. B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100M-7-46-19068

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 22

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Baker Rest Home Latisquama Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. ELLA (Riley) SLAMIN WALSH
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. (Usual place of abode) (Widow of 2 husbands above) St. 109 WAVERLY ST. FRAMINGHAM (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) rest home (Specify whether) years 6 months days. In this community 70 yrs. mos. days.

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: WIDOW

5a If married, widowed or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Thos. Slamin & Thos. Walsh (Husband's name in full)

6 Age of husband or wife if alive: both above DEAD years

7 IF STILLBORN, enter that fact here.

8 AGE: 70 Years 5 Months 21 Days | If less than 1 day: Hours Minutes

9 Usual Occupation: Retired

10 Industry or Business: not known

11 Social Security No.: none

12 BIRTHPLACE (City) (State or Country): Framingham Mass.

PARENTS

13 NAME OF FATHER: CHRISTOPHER RILEY

14 BIRTHPLACE OF FATHER (City) (State or Country): County Cork Ireland

15 MAIDEN NAME OF MOTHER: MARY BRADLEY

16 BIRTHPLACE OF MOTHER (City) (State or Country): County Cork Ireland

17 Informant (Address): Florence Diard (Relation, if any) niece — Raleigh St. Glendale Calif.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Samuel H. Pelter
(Signature of Agent of Board of Health or other)

Agent. (Official Designation) 11/21/47 (Date of Issue of Permit)

By C.M.O.

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Oct (Month) 21 (Day) 47 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June, 19 47, to Oct 21, 19 47

I last saw her alive on Oct 21, 19 47 death is said to have occurred on the date stated above, at 4 A M m.

Immediate cause of death: Chronic Myocarditis & Arteriosclerosis.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death): Diabetes Hypertension

Major findings: Of operations — Date of

Of autopsy

What test confirmed diagnosis?

Duration IMPORTANT

IMPORTANT

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) J. F. Cunningham, M. D.
(Address) Main St Date Oct 22 19 47

21 St. Stephens Cemetery Framingham
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL October 23, 1947 19

22 NAME OF FUNERAL DIRECTOR: John A. Cunningham
ADDRESS: Framingham

Received and Filed October 25 19 47

James E. Roberts
(Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 23

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro

No. Clifford Road, St. Southboro (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Juliette (Wright) Field (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Clifford Road St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 35 years ..... months ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
female	white	widowed

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF George F. Field
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 81 Years 4 Months 23 Days | If less than 1 day Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Holden Mass.

PARENTS

13 NAME OF FATHER James F. Wright

14 BIRTHPLACE OF FATHER (City) (State or country) Worcester Mass.

15 MAIDEN NAME OF MOTHER Mary Turner

16 BIRTHPLACE OF MOTHER (City) (State or country) Worcester Mass.

17 Informant (Address) James Penelligan, (Relation if any) (nephew) 16 Maxwell Rd., Winchester Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Tefft
(Signature of Agent of Board of Health or other)

Burial Agent Oct 30-47
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Oct (Month) 29 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 13, 1947, to Oct 29, 1947

I last saw her alive on Oct 25, 1947, death is said to have occurred on the date stated above, at 8 A.M.

Immediate cause of death ..... Duration Important

Myocarditis chronic 10 years

Due to Arteriosclerosis -2-

Due to .....

Other conditions (Include pregnancy within 3 months of death) Important

Major findings: Of operations none Date of .....

Of autopsy none Physician

What test confirmed diagnosis? Physical examination

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Roland D. Sawtell M.D.

(Address) Waltham Date Oct 29 1947

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL October 31, 1947

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS 156 Otting Ave., Marlboro

Received and filed Oct 31 1947

John J. Babson
(Registrar)

A TRUE COPY ATTEST:

RM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Sent to Mail
(City or town making return)

Registrar's Number 24

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town) No. Baker Rest Home St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Charles Fred Davis (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. 219 Lincoln St. Marlboro Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years 11 months days. In this community 88 years 4 months days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced HUSBAND OF Ada A. Wing (Give maiden name of wife in full)

(or) WIFE OF (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 89 Years 3 Months 1 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired foreman

10 Industry or Business: Shoe factory

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Marlboro

PARENTS

13 NAME OF FATHER Charles Fred Davis

14 BIRTHPLACE OF FATHER (City) (State or country) Marlboro Mass.

15 MAIDEN NAME OF MOTHER Helen Knights

16 BIRTHPLACE OF MOTHER (City) (State or country) Not known

17 Informant Willis G. Davis (Relation, if any Son)
(Address) 219 Lincoln St. Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Feeley
(Signature of Agent of Board of Health or other)

Burial Agt. (Official Designation) Nov. 14 1947 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov (Month) 14 (Day) 47 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 1946, 19..., to Nov 13, 1947

I last saw him alive on Nov 13, 1947, death is said to have occurred on the date stated above, at 6.30 A. M.

Immediate cause of death: (a) Arteriosclerotic Heart disease

Due to: Senility

Due to:

Other conditions: Chronic Myocarditis
(Include pregnancy within 3 months of death)

Major findings: Of operations

Date of

Of autopsy

What test confirmed diagnosis?

Duration Important

Important

Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. J. Cunningita MD, M.D.

(Address) Main St Hopkinton Date Nov 14 1947

21 Rocklawn Marlboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Nov. 16, 1947

22 NAME OF FUNERAL DIRECTOR Sumner G. Gage

ADDRESS 15 Cotting Ave., Marlboro

Received and filed Dec 2 1947

James E. Palermi
(Registrar)

A TRUE COPY ATTEST: Asst

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK -- THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

30m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Boston (City or town making return)

Registered No. 10200

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town); No. Mass.General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clarissa F Clapp (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) 25

(a) Residence. No. West Main St. Southboro Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) years months 21 days. (Specify whether) In this community yrs. mos. 21 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ... (Give maiden name of wife in full)

(or) WIFE of Henry J Clapp (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE 80 Years 10 Months 23 Days | If less than 1 day ... Hours ... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At Home

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Rutland Mass.

PARENTS

13 NAME OF FATHER: Samsen Seaverns

14 BIRTHPLACE OF FATHER (City) (State or country): Unknown

15 MAIDEN NAME OF MOTHER: Cornelia Titus

16 BIRTHPLACE OF MOTHER (City) (State or country): Unknown

17 Informant (Address): W I Seaverns (Relation, if any) Cousin

A TRUE COPY.

ATTEST: ... (Registrar of city or town where death occurred)

DATE FILED Dec, 1 19 47

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov.26/47 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1947, to Nov. 26, 1947. I last saw her alive on Nov. 26, 1947, death is said to have occurred on the date stated above, at 2:20P m.

	Duration
Immediate cause of death: Pulmonary embolism, massive (source not determined)	10 Mi
Due to:	
Due to: Carcinoma of rectum	6 Mos Plus
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Lysis of adhesions and enterostomy Date of Operations 11-6-47

colostomy Date of autopsy 10-21-47

What test confirmed diagnosis? autopsy

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify ...

(Signed) F Haase Jr. M.D.

(Address) Mass.General Hospt 19 11-26-47

21 PLACE OF BURIAL, CREMATION OR REMOVAL Mountain View- (Cemetery) Shrewsbury (City or town) Mass.

DATE OF BURIAL Nov.29/47 19

22 NAME OF FUNERAL DIRECTOR S C Gage

ADDRESS Marlboro Mass.

Received and filed Dec 31 19 47

Frances E Nelson

(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 26

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John B. Pearse (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Newton St. Southboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Hospital years months 2 days. In this community yrs. mos. days. (Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced HUSBAND of Lillian Tucker (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 72 Years 5 Months 14 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Truckman

10 Industry or Business: Retired

11 Social Security No. 019-10-6309A

12 BIRTHPLACE (City) (State or country) Cornwall, England

PARENTS

13 NAME OF FATHER: Thomas Pearse

14 BIRTHPLACE OF FATHER (City) (State or country): Cornwall, England

15 MAIDEN NAME OF MOTHER: Cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country): Cannot be learned

17 Informant (Address) Mrs. Lillian M. Pearse Wife (Relation, if any) Newton St., Southboro, Mass.

A TRUE COPY. ATTEST: Wm. L. Walsh (Registrar of city or town where death occurred)

DATE FILED December 20, 1947

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 28, 1947 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from August 14, 1947, to November 28, 1947

I last saw him alive on November 27, 47 death is said to have occurred on the date stated above, at 5:00 A.M.

	Duration
Immediate cause of death: Inanition	2 mos.
Due to: Progressive bulbar paralysis	11 mos
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Date of	
Of autopsy	
What test confirmed diagnosis?	

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date 11/28/47

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural-Southboro (Cemetery) (City or Town)

DATE OF BURIAL November 30, 1947

22 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 62 W. Main St., Westboro, Mass.

Received and filed Dec. 24 1947

John J. Sabene (Registrar of City or Town where deceased resided)

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-6-2-42-8855

MARGIN RESERVED FOR BINDING

Sent to Brookline

To be filed for burial permit with Board of Health or its Agent.

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 27

1 PLACE OF DEATH: Worcester (County) — South Lancaster (City or Town) — No. ____ Winter St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN - IMPORTANT

2 FULL NAME Lena Stockwell Horn (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) ____

(a) Residence. No. 13 Garrison Road St. Brookline (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution ____ years ____ months ____ days. (Before death) (Specify whether) In this community — yrs. — mos. 3 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): single

5a If married, widowed, or divorced
HUSBAND of ____ (Give maiden name of wife in full)
(or) WIFE of ____ (Husband's name in full)

6 Age of husband or wife if alive ____ years

7 IF STILLBORN, enter that fact here.

8 AGE 76 Years 10 Months 4 Days | If less than 1 day ____ Hours ____ Minutes

9 Usual Occupation: Farm Woman

10 Industry or Business: ~

11 Social Security No. ____

12 BIRTHPLACE (City) (State or country): Waterbury Conn.

PARENTS

13 NAME OF FATHER: Charles H Horn

14 BIRTHPLACE OF FATHER (City) (State or country): Maine

15 MAIDEN NAME OF MOTHER: Emily Wentworth

16 BIRTHPLACE OF MOTHER (City) (State or country): New Hampshire

17 Informant (Address): William D. Eldridge 6 Garrison St, Boston — Relation, if any: (Brother)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James A Fletcher M.D.
(Signature of Agent of Board of Health or other)

12-1-47
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Nov (Month) 30 (Day) 1947 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1947, to Nov 30, 1947

I last saw her alive on Nov 30, 1947, death is said to have occurred on the date stated above, at 3.15 P. m.

Immediate cause of death: Myocarditis Chronic — Duration: 3yrs +

Due to: Arteriosclerosis Chronic — Duration: -2-

Due to: ____

Other conditions: none (include pregnancy within 3 months of death)

IMPORTANT

Major findings:
Of operations: none — Date of: ____
Of autopsy: none
What test confirmed diagnosis? Physical Examination

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify ____
(Signed) Roland A Newton, M. D.
(Address) Westboro Mass Date Dec 2, 1947

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec 3 1947

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15 Cutting Ave., Marlboro

Received and filed Dec 2 1947
Frances E Raheni
(Registrar)

301

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 1

1 PLACE OF DEATH: (County) Worcester ... (City or Town) Southborough ... No. Cordaville Road St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Ellen A. O'Neil (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Cordaville Road St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 12 years ..... months ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: widow

5a If married, widowed, or divorced
HUSBAND OF ..... (Give maiden name of wife in full)
(or) WIFE OF ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 72 Years 6 Months 5 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: At home

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) Harkness (State or country) New York

PARENTS

13 NAME OF FATHER Michael O'Neill

14 BIRTHPLACE OF FATHER (City) Harkness (State or country) New York

15 MAIDEN NAME OF MOTHER Johanna Sullivan

16 BIRTHPLACE OF MOTHER (City) Unknown (State or country)

17 Informant Wm. J. O'Neill (Address) Parker St. Cordaville (Relation, if any) (Brother)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James H. Welker M.D.
(Signature of Agent of Board of Health or other)

Agent to B of H 1/10/48
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January 8 1948
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1948 to Jan 8, 1948

I last saw her alive on Jan 8, 1948, death is said to have occurred on the date stated above, at 7 P. M.

Immediate cause of death
Pneumonia Bronchial — Duration Important 1 week

Due to .....

Due to .....

Other conditions (Include pregnancy within 3 months of death) Arteriosclerosis — 2 — Important

Major findings: Of operations none — Date of .....

Of autopsy none

What test confirmed diagnosis? Physical examination

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Roland F. Vaughan M.D.

(Address) 9 Central Working Date 1/9 1948

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Jan. 10, 1948

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS 15 Cutting Ave., Marlboro

Received and filed January 12 1948

Frances E. Nelson (Registrar)

A TRUE COPY ATTEST:

100m-(c)-3-46-18278

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

N.B. WHERE ... carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH ... it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

FORM R-303

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. chap. 46, section 10, requires physicians to insert a recital to that effect.

50m-(h)-1-45-15510

MARGIN RESERVED FOR BINDING

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 2

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank L. Haynes (If deceased is a married, widowed or divorced woman, give also maiden name.)

Physician — Important (Was deceased a U. S. War Veteran, If so specify WAR) .....

(a) Residence. No. Main St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) ..... years ..... months ..... days. (Specify whether) In this community 7 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 63 Years 11 Months 8 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: State Dept. Conservation

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

13 NAME OF FATHER Daniel W. Haynes

14 BIRTHPLACE OF FATHER (City) (State or country) Framingham, Mass.

15 MAIDEN NAME OF MOTHER Charlotte Farley

16 BIRTHPLACE OF MOTHER (City) (State or country) England

17 Informant Mrs. Robert Burnett (Address) Main St., Southboro (Relation, if any) Sister

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James H Nelden - H.M.O.
(Signature of Agent of Board of Health or other)

Agent. 1/12/48
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH January (Month) 11 (Day) 1948 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury .....

Nature of Injury .....

While at work? ..... Was there an autopsy? Yes

21 Was disease or injury in any way related to occupation of deceased? Yes

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date Jan 11 1948

22 Place of Burial, Cremation or Removal. Edgell Grove (City or Town) Framingham, Mass.

DATE OF BURIAL Jan. 13, 1948

23 NAME OF FUNERAL DIRECTOR Frederick A. Cookson

ADDRESS Framingham, Mass.

Received and filed Jan 14 1948

A TRUE COPY ATTEST: Frances E Roberts (Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

30m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Chelsea (City or town making return)

Registered No. 2A 22

1 PLACE OF DEATH: Suffolk (County); Chelsea (City or Town); No. U. S. Naval Hospital, St. Chelsea (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harold Sawin Jennison (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR) WWI

(a) Residence. No. Upland Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Hospital (Before death) (Specify whether) years 1 months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Florence Chatham (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 53 years

7 IF STILLBORN, enter that fact here.

8 AGE 56 Years 11 Months 14 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Supervisor

10 Industry or Business: Accelo Corp.

11 Social Security No. 373 05 9123

12 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

13 NAME OF FATHER: Charles V. Jennison

14 BIRTHPLACE OF FATHER (City) (State or country) Southboro, Mass.

15 MAIDEN NAME OF MOTHER: Mary Sawin

16 BIRTHPLACE OF MOTHER (City) (State or country) Southboro, Mass.

17 Informant (Address) Mrs. Florence Jennison (Relation, if any) (wife) Upland Rd., Southboro, Mass.

A TRUE COPY.
ATTEST: Joseph A. Tyrrell (Registrar of city or town where death occurred)
DATE FILED 1-16-48 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan. 15, 1948 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from 16 Dec., 1947, to Jan. 15, 1948
I last saw him alive on 15 Jan 1948, death is said to have occurred on the date stated above, at 9:15P m.

Immediate cause of death: peritonitis — Duration

Due to: Carcinoma Rectum

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations: Carcinoma rectum Date of 1/10/48

Of autopsy: Same

What test confirmed diagnosis? Autopsy

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) G. F. Sager, M. D.
(Address) USNH, Chelsea, Mass. Date 1/16 1948

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural (Cemetery) Southboro, Mass (City or Town)
DATE OF BURIAL Jan. 18, 1948 19

22 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlboro, Mass.

Received and filed Jan 19 1948
John J. Bateau (Registrar of City or Town where deceased resided)

ORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 3

1 PLACE OF DEATH: (County) Worcester; (City or Town) Fayrille; No. Pleasant St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Selina Fay (nee Paluzzi)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Pleasant St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 30 years ..... months ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF Dominic Fay
(Husband's name in full)

6 Age of husband or wife if alive 64 years

7 IF STILLBORN, enter that fact here.

8 AGE 59 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: .....

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Italy

PARENTS

13 NAME OF FATHER Gene Paluzzi

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER can not be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) " " " "

17 Informant Dominic Fay (Address) Pleasant St, Fayrill — Relation, if any (husband)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

James A Fisher M.D.
(Signature of Agent of Board of Health or other)

Agent. Jan. 20, 1948
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Jan (Month) 19 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1948 to Jan 19, 1948
I last saw h alive on Jan 19, 1948, death is said to have occurred on the date stated above, at 11.50 A.M.

Immediate cause of death — Duration Important
Cerebral hemorrhage — 7 days
Due to Arteriosclerosis — years
Due to .....
Other conditions (Include pregnancy within 3 months of death) — Important
Major findings: Of operations no operation — Physician
Date of .....
Of autopsy none
What test confirmed diagnosis? by examination

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) C. W. S Smith M.D.
(Address) Marlboro Date 1/9 1948

21 Rural Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Jan 22 1948

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed February 9 1948
Frances E Rebare
(Registrar)

A TRUE COPY ATTEST: asst Clerk

FORM R-301 A

N. B.— WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-(8)-1-45-15510

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 4

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lydia A. Still (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Latisquama Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) 3 years — months — days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full) (or) WIFE of Charles A. Still (Husband's name in full)

6 Age of husband or wife if alive — years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years 10 Months 5 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: at home

10 Industry or Business:

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) So. Dover New York

PARENTS

13 NAME OF FATHER Herman Ellsworth

14 BIRTHPLACE OF FATHER (City) So. Dover (State or country) New York

15 MAIDEN NAME OF MOTHER Mary Stevens

16 BIRTHPLACE OF MOTHER (City) — (State or country) New York

17 Informant Mrs. Gertrude Kennedy (Address) Hudson Mass (Relation, if any) Granddaughter

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued.

James F. Fuller M.D.
(Signature of Agent of Board of Health or other)

Agent.
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Jan. (Month) 24 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1945, 19.., to Jan 23, 1948, I last saw her alive on Jan 23, 1948, death is said to have occurred on the date stated above, at 11:15 A.M.

Duration

Immediate cause of death Bronchopneumonia — IMPORTANT — 3 days

Due to Bronchitis

Due to

Other conditions Chronic Myocarditis (Include pregnancy within 3 months of death) — IMPORTANT

Major findings: Of operations ..... Date of .....

Of autopsy .....

What test confirmed diagnosis? .....

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) James F. Fuller, M. D.
(Address) Southboro Date Jan 26 1948

21 Fairview Cemetery Hudson
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Jan. 26, 1948

22 NAME OF FUNERAL DIRECTOR William B. Leland
ADDRESS Hudson Mass

Received and filed Jan 26 1948
Frances E. Rabare
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-10-'39. No. 8427-f

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 5

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town); No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Smiddy (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Turnpike Rd. St. Fayville Mass (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution, 2 dys years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	wid

5a If married, widowed or divorced HUSBAND of Catherine Eagan (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 76 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: retired foreman

10 Industry or Business: M W W

11 Social Security No.

12 BIRTHPLACE (City or town) Framingham (State or country) Mass

PARENTS

13 NAME OF FATHER: Jeremiah Smiddy

14 BIRTHPLACE OF FATHER (City or town) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Katherine Pomphrey

16 BIRTHPLACE OF MOTHER (City or town) (State or country): Ireland

17 Informant (Address) Earl Smiddy Turnpike Rd Fayville Relation, if any

A TRUE COPY. F. J. Bertrand

ATTEST: (Registrar of city or town where death occurred)

DATE FILED Feb 3 1948

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Feb (Month) 1 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1946, to Feb 1, 1948

I last saw h. im alive on Feb 1, 1948, death is said to have occurred on the date stated above, at 11.30 A.M.

Immediate cause of death	Duration
coronary sclerosis	2 yrs
Due to	
Gen arterio sclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Date of
Of autopsy
What test confirmed diagnosis? Phys signs

PHYSICIAN

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) William D. Roche M. D.

(Address) Marlborough Date 2-2- 1948

21 PLACE OF BURIAL, CREMATION OR REMOVAL (Cemetery) Rural Cem (City or Town) Southbor

DATE OF BURIAL Feb 4 1948

22 NAME OF FUNERAL DIRECTOR

ADDRESS

Received and filed Feb 1948

(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Boston (City or town making return)

Registered No. 1732 54

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town); No. Mass. General Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ralph E Conder (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. East Main St. Southboro Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months 2 days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or div. HUSBAND of: Mabel A Pierce (Give maiden name of wife in full)

(or) WIFE of: (Husband's name in full)

6 Age of husband or wife if alive: years

7 IF STILLBORN, enter that fact here.

8 AGE 61 Years 10 Months 2 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Adv. Manager

10 Industry or Business: Boston Woven Hose & Rubber

11 Social Security No.: 023-05-6251

12 BIRTHPLACE (City) (State or country): Cambridge Mass.

PARENTS

13 NAME OF FATHER: Charles Conder

14 BIRTHPLACE OF FATHER (City) (State or country): Cambridge Mass.

15 MAIDEN NAME OF MOTHER: ---- -----

16 BIRTHPLACE OF MOTHER (City) (State or country): ----- -----

17 Informant (Address): J. Soule (Relation, if any) Daughter

A TRUE COPY. ATTEST: (Registrar of city or town where death occurred)

DATE FILED Feb. 24/48 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Feb. 18/48 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1948, to Feb. 18, 1948. I last saw him alive on Feb. 18, 1948, death is said to have occurred on the date stated above, at 11 PM m.

	Duration
Immediate cause of death: Thrombosis right middle cerebral artery	3 Das.
Due to: Hypertension	7 Yrs Plus
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations: Date of: Of autopsy: What test confirmed diagnosis? Autopsy

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) F Haase Jr., M. D.

(Address) Mass. General Hospt Date 2-19 19 48

21 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem-Cambridge Mass. (Cemetery) (City or Town)

DATE OF BURIAL Feb. 20/48 19

22 NAME OF FUNERAL DIRECTOR: J S Waterman & Sons

ADDRESS: Boston Mass.

Received and filed Mar. 1 19 48

(Registrar of City or Town where deceased resided)

ORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

10m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's Number 6

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. newton St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Rose Ann Mattioli (nee Ferguson)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. newton St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 65 years ..... months ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Married

5a If married, widowed, or divorced
HUSBAND OF ..... (Give maiden name of wife in full)
(or) WIFE OF Ercole Mattioli
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 89 Years 9 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: at Home

10 Industry or Business: —

11 Social Security No. —

12 BIRTHPLACE (City) (State or country): Ireland

PARENTS

13 NAME OF FATHER: Owen Ferguson

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Mary Ann M'Manus

16 BIRTHPLACE OF MOTHER (City) (State or country): Ireland

17 Informant: Mrs Thomas McCarthy (Relation, if any: Daughter)
(Address) newton st Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James F. Parker, M.D.
(Signature of Agent of Board of Health or other)

Agent 2/29/48
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: February (Month) 27 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1948 to Feb 27, 1948
I last saw h er alive on Feb 27, 1948, death is said to have occurred on the date stated above, at 9:00 P.M.

Immediate cause of death
Arteriosclerotic Heart Disease — Duration Important: yrs

Due to —

Due to —

Other conditions (Include pregnancy within 3 months of death) — Important

Major findings: Of operations — none

Date of —

Of autopsy —

What test confirmed diagnosis? Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) William D Roche M.D.
(Address) Marlboro Date 3/1 1948

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL March 1 1948

22 NAME OF FUNERAL DIRECTOR Wm M. Tighe
ADDRESS Marlboro Mass

Received and filed March 1 1948
Frances E Roberts (Registrar)

A TRUE COPY ATTEST:

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 7

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Southville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Fred A. Hill
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Southville Rd. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years — months — days. — In this community 22 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Matilda (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 76 Years 9 Months 8 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Foreman - retired

10 Industry or Business: Boston Albany Railroad

11 Social Security No. 714-14-3788A

12 BIRTHPLACE (City) (State or country) St. Johnsbury Vermont

PARENTS

13 NAME OF FATHER Buran Hill

14 BIRTHPLACE OF FATHER (City) (State or country) St. Johnsbury Vermont

15 MAIDEN NAME OF MOTHER Rhoda - Cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) Cannot be learned Vermont

17 Informant (Address) Mrs. Matilda Hill Southville Rd. Southboro, Mass. Relation, if any wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James Miller - M.D.
(Signature of Agent of Board of Health or other)

Agent
(Official Designation)

3/10/1948
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March (Month) 10 (Day) 1948 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify)
Date of occurrence 19
Where did injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of injury
Nature of injury
While at work? nr Was there an autopsy? nr

21 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) Walter S Mooney, M. D.
(Address) Westborough Date Mar 10 1948

22 Rural Cemetery Worcester Mass.
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL March 12, 1948

23 NAME OF FUNERAL DIRECTOR Irvin W. Harper
ADDRESS 62 N. Main St. Southboro Mass.

Received and filed March 11 1948 19
John J. Perkins
(Registrar)

ORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registrar's Number 8

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Oak Hill Road St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME Mabel (Currier) Stagg (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Oak Hill Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) ..... years ..... months ..... days. In this community years 3 months 14 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND OF .....
(Give maiden name of wife in full)
(or) WIFE OF James Frank Stagg
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 80 Years 6 Months 28 Days | If less than 1 day Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No. .....

12 BIRTHPLACE (City) Charlestown (State or country) Mass.

PARENTS

13 NAME OF FATHER Stephen P. Currier

14 BIRTHPLACE OF FATHER (City) Andover (State or country) New Hampshire

15 MAIDEN NAME OF MOTHER Elizabeth Chase

16 BIRTHPLACE OF MOTHER (City) Eaton (State or country) New Hampshire

17 Informant (Address) Mrs. Ida F. Gray Oak Hill Rd., Fayville Relation, if any Sister

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James H. Wheeler M.D.
(Signature of Agent of Board of Health or other)

Agent
(Official Designation)

3/16/48
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Mar. (Month) 16, (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1947, to Mar. 16, 1948

I last saw her alive on Mar. 15, 1948, death is said to have occurred on the date stated above, at 5:15 A.M.

Immediate cause of death: Carcinoma of the breast — Duration Important: 2 years

Due to: .....

Due to: .....

Other conditions (Include pregnancy within 3 months of death) — Important

Major findings: Of operations ..... Date of .....

Of autopsy .....

What test confirmed diagnosis? Clinical

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Wilfred H. Watson M.D.

(Address) Northboro Date 3/16/1948

21 Glenwood Everett
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL March 18, 1948

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS Cotting Ave., Marlboro Mass.

Received and filed March 17 1948

John J. Rabbett (Registrar)

A TRUE COPY ATTEST:

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 9

1 PLACE OF DEATH: (County) Worcester; (City or Town) Fayville; No. Turnpike Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Louis A Fay (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Turnpike Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Widowed

5a If married, widowed, or divorced. HUSBAND of Florence B O'Leary (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 75 Years 7 Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired

10 Industry or Business: Cemetery Worker

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Southboro Mass

PARENTS

13 NAME OF FATHER Francis A Fay

14 BIRTHPLACE OF FATHER (City) (State or country) Southboro Mass

15 MAIDEN NAME OF MOTHER Flora A Lawrence

16 BIRTHPLACE OF MOTHER (City) (State or country) Marlboro Mass

17 Informant (Address) Mrs Gerald E Jolly Turnpike Rd Fayville Relation, if any Daughter

I HEREBY CERTIFY that a satisfactory, standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

James H Fetter, M.D. (Signature of Agent of Board of Health or other)

Agent. (Official Designation) March 31, 1948 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH March 29 1948 (Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury

Nature of Injury

While at work? Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F Mahoney, M. D.

(Address) Marlborough Date March 29 1948

22 Rural Southboro Mass
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL March 31 1948

23 NAME OF FUNERAL DIRECTOR Wm M Tighe

ADDRESS Marlboro Mass

Received and filed April 1 1948

Frances E Raberu (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.— WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m-9-44-14955

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 10

PLACE OF DEATH

1 (County) Southboro

(City or Town)

No. Baker Rest Home St. { (If death occurred in a hospital or institution, give its NAME instead of street and number) }

2 FULL NAME Mary A Dundas Bill

(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT { (Was deceased a U. S. War Veteran, if so specify WAR) }

(a) Residence. No. Lake Quanna Rd St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Rest Home / years months days. In this community / yrs. mos. days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Widow

5a If married, widowed or divorced
HUSBAND of
(Give maiden name of wife in full)
(or) WIFE of Walter Bill
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE	60 Years	Months	Days	If less than 1 day Hours	Minutes

9 Usual Occupation: Home work

10 Industry or Business: own home

11 Social Security No.

12 BIRTHPLACE (City) (State or Country) Clinton Mass.

PARENTS

13 NAME OF FATHER John Dundas

14 BIRTHPLACE OF FATHER (City) (State or Country) Ireland

15 MAIDEN NAME OF MOTHER Eliza McGee

16 BIRTHPLACE OF MOTHER (City) (State or Country) Ireland

17 Informant Thos J Dundas (Relation, if any) Son
(Address) 41 Washington St Clinton

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health April 8, 48
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 7 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from July, 1948, to Apr 6, 1948

I last saw her alive on Apr 6, 1948, death is said to have occurred on the date stated above, at 3.15 p. m.

	Duration
Immediate cause of death: Acute cardiac dilitation	IMPORTANT
Due to: Chronic myocarditis & congestive failure	15 yrs.
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings: Of operations Date of

Of autopsy None

What test confirmed diagnosis? Clinical

IMPORTANT

Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) John J. Lahone M.D.

(Address) Marlboro Mass Date 4/8, 1948

21 St Johns Lancaster
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL April 10, 1948

22 NAME OF FUNERAL DIRECTOR Martin Murphy Co

ADDRESS Clinton Mass.

Received and Filed April 9, 1948

John J. Rabbett
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 10a

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Jennie Lucy Dix (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. 7 Wood St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In hospital or institution hospital (Specify whether) years 1 months 19 days. In this community yrs. mos. days.
(Before death)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Leonard Dix (Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 84 Years 7 Months 25 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: housewife

10 Industry or Business: at home

11 Social Security No.

12 BIRTHPLACE (City) (State or country) East Mont Pelier, Vt.

PARENTS

13 NAME OF FATHER Charles Templeton

14 BIRTHPLACE OF FATHER (City) (State or country) Montpelier, Vt.

15 MAIDEN NAME OF MOTHER Mary Jane Copeland

16 BIRTHPLACE OF MOTHER (City) (State or country) Vt.

17 Informant (Address) Charles T. Dix 7 Wood St. Southboro Relation, if any Son

A TRUE COPY.
ATTEST: W. L. Walsh
(Registrar of city or town where death occurred)

DATE FILED April 15, 1948 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April 13, 1948 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1948 to April 12, 1948

I last saw h..... alive on ....., 19....., death is said to have occurred on the date stated above, at ..... m.

Immediate cause of death	Duration
Due to Hypostatic Pneumonia	
Due to Senility arteriosclerosis	
Other conditions. Chronic Myocaroitis (Include pregnancy within 3 months of death)	

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) J. F. Annunziata, M. D.
(Address) Hopkinton, Mass. Date 4/13 19 48

21 PLACE OF BURIAL, CREMATION OR REMOVAL Elswood, Barre, Vt. (Cemetery) (City or Town)
DATE OF BURIAL April 16, 1948 19

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS Framingham, Mass.

Received and filed May 1 19 48
(Registrar of City or Town where deceased resided)

ORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(c)-3-46-18278

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's Number 11

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. East Main St. (If death occurred in a hospital or institution give its NAME instead of street and number)

2 FULL NAME James Fairbairn Telfer (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence: No. East Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months days. In this community 47 years months days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced HUSBAND OF Florence Dubuis (Give maiden name of wife in full)

(or) WIFE OF (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 52 Years 7 Months 15 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Shipper

10 Industry or Business: Draper Corporation (Machinery)

11 Social Security No. 033-07-1935

12 BIRTHPLACE (City) (State or country) Coldstream Scotland

PARENTS

13 NAME OF FATHER James J. Telfer

14 BIRTHPLACE OF FATHER (City) (State or country) Scotland

15 MAIDEN NAME OF MOTHER Eleanor Turnbull

16 BIRTHPLACE OF MOTHER (City) (State or country) Gateshead, Newcastle on Tyne England

17 Informant (Address) Margaret Telfer (Sister) E. Main St. Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone M.D.
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) Apr. 26, 48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH April (Month) 25 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1941, to April 25, 1948

I last saw him alive on April 25, 1948, death is said to have occurred on the date stated above, at 11.50 P.M.

Immediate cause of death: Carcinoma - rectum — Duration Important: 2 yrs +

Due to — Duration Important

Due to — Duration Important

Other conditions (Include pregnancy within 3 months of death) — Important

Major findings: Carcinoma - rectum
Of operations — Date of 6/1/1946
biopsy
Of autopsy —
What test confirmed diagnosis? biopsy

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Richard P. Vantum M.D.
(Address) 9 Central Worcester Date 4/26 1948

21 Rural Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL April 28, 1948

22 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS 15 Cottage Ave., Marlboro

Received and filed April 27 1948
John J. Rabbett (Registrar)

A TRUE COPY ATTEST:

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

30m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 13

1 PLACE OF DEATH
Worcester (County)
Southboro (City or Town)
No. Metropolitan Reservoir St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret C Wykes
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT
(Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. 2 Larch St St. Worcester Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of .....
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 36 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Draftsmoman

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country): Waltham Mass (or)

PARENTS

13 NAME OF FATHER: Herbert Wykes

14 BIRTHPLACE OF FATHER (City) (State or country): England

15 MAIDEN NAME OF MOTHER: Catherine Fitzswilliam

16 BIRTHPLACE OF MOTHER (City) (State or country): Scotland.

17 Informant (Address) ..... (Relation, if any .....)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Madeleine L. Lebeau
(Signature of Agent of Board of Health or other)

Agent May 7 1948
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Probably in April (Month) ..... (Day) 1945 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

self inflicted wounds of wrists ankles abd left arm
asphyxiation by drowning

20 Accident, suicide, or homicide (specify) Presumably Suicide
Date of occurrence Early in April 1945
Where did Injury occur? Southborough Westborough-Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Metropolitan Reservoir
(Specify type of place)
Manner of Injury .....
Nature of Injury asphyxiation by drowning
While at work? no Was there an autopsy? yes

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Walter F McInerney, M. D.
(Address) Westborough Date May 7 1945

22 Pine Grove Boylston
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL May 10 1948

23 NAME OF FUNERAL DIRECTOR Carl D. Nordgren
ADDRESS Worcester, Mass.

Received and filed May 27 1948
Francis E Roberts
(Registrar)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m (e)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

MARLBOROUGH
(City or town making return)

Registered No. 12

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town); No. MARL HOSP St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Katherine Augusta Hall ((If U. S. War Veteran, specify WAR)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Oak Hill Road St. Fayville Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George R. Hall
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 84 Years 10 Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: housework

10 Industry or Business: own home

11 Social Security No.

12 BIRTHPLACE (City) Northboro
(State or country) Mass

PARENTS

13 NAME OF FATHER: Patrick Kelly

14 BIRTHPLACE OF FATHER (City) Ireland
(State or country)

15 MAIDEN NAME OF MOTHER: cannot be learned

16 BIRTHPLACE OF MOTHER (City) " " "
(State or country)

17 Informant Mrs Fanney Marshall (Relative) dau
(Address) 43 Chester St. Somerville

A TRUE COPY. F. J. Bertrand
ATTEST:
(Registrar of city or town where death occurred)

DATE FILED May 6 1948

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH May 2 1948
(Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1948 to May 1, 1948
I last saw her alive on May 1 1948 Death is said to have occurred on the date stated above, at 5.20 A.M.

Immediate cause of death — Duration

arterio sclerosis 10 yrs

Due to

Due to diabetes mellitus 20 yrs

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations Date of
Of autopsy
What test confirmed diagnosis? phys findings

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) William J. Delaney, M. D.
(Address) 186 Main St. City Date 5-2-1948

21 PLACE OF BURIAL, CREMATION OR REMOVAL Maplewood Cem Marlboro
(Cemetery) (City or Town)
DATE OF BURIAL May 5 1948

22 NAME OF FUNERAL DIRECTOR W.J. Rockwell
ADDRESS Auburn St. Watertown Mass

Received and filed May 10 1948
John J. Baker
(Registrar of City or Town where deceased resided)

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

50m (g)-1-41-4667

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 14

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Melindy Rest Home Melendy St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME EDMOND F. HAYES
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Huntington Ave St. Marlboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) years 8 months days. In this community yrs. mos. days. (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 85 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Shoe Worker

10 Industry or Business: Curtis Shoe Co.

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Maynard Mass

PARENTS

13 NAME OF FATHER Edmond Hayes

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Ellen Moynihan

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Lee L. Hayes 38 Barnard Rd. Edmond (Relation, if any) Husband

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) June 28 1948 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH June (Month) 27 (Day) 1948 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Natural causes - Presumably coronary thrombosis. Contributory cause - Prostatectomy, arteriosclerosis.

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury

Nature of Injury

While at work? Was there an autopsy?

21 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) S. Allen Greene, M. D.

(Address) Hospital Mun. Date June 27 1948

22 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal (City or Town)

DATE OF BURIAL June 29 1948

23 NAME OF FUNERAL DIRECTOR John J. Bowen

ADDRESS 70 W. Main St. Marlboro

Received and filed June 30 1948

John J. Bakens
(Registrar)

ORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(1)-1-45-15510

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

(City or town making return)

STANDARD CERTIFICATE OF DEATH

Registrar's No. 15

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Duarte Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret V. Collins (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 245 South St. (Usual place of abode) (If nonresident, give city or town and State) Marlborough

Length of stay: In hospital or Institution (Before death) years months 2 days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED: Single

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Maid

10 Industry or Business: St. Mark's School Southboro

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Ireland

PARENTS

13 NAME OF FATHER William Collins

14 BIRTHPLACE OF FATHER (City) (State or country) Waterford Ireland

15 MAIDEN NAME OF MOTHER Margaret V Burke

16 BIRTHPLACE OF MOTHER (City) (State or country) Waterford Ireland

17 Informant (Address) Mrs Helen Bourgeois 11 Eccis Ave Marlboro Relation, if any (Niece)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, B of H (Official Designation) July 6, 48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 5 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 4, 1948, to July 5, 1948

I last saw her alive on July 5, 1948, death is said to have occurred on the date stated above, at 6.25 A.M.

	Duration IMPORTANT
Immediate cause of death: Cerebral Embolism	48 hrs
Due to Chronic Myocarditis	6 mo
Due to Arteriosclerosis	years
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations none Date of 7/5/48

Of autopsy none

What test confirmed diagnosis? Examination

IMPORTANT Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) C. W. Smith, M. D.
(Address) Marlboro Date 7/5 1948

21 Immaculate Conception Marlboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 7 1948

22 NAME OF FUNERAL DIRECTOR John J. Brown
ADDRESS 95 Main St. Marlboro

Received and filed June 7 July 1948
John J. Rabbitt
(Registrar)

A TRUE COPY ATTEST:

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Cordaville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edward William Bartlett
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR) WW 2

(a) Residence. No. 75 Main Circle St. Shrewsbury
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of --
(or) WIFE of
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive -- years

7 IF STILLBORN, enter that fact here. --

8 AGE 21 Years 10 Months 25 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Express Man

10 Industry or Business: Express

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Shrewsbury Mass

PARENTS

13 NAME OF FATHER: Wilbur S. Bartlett

14 BIRTHPLACE OF FATHER (City) (State or country) Shrewsbury Mass.

15 MAIDEN NAME OF MOTHER: Evelyn P. Warner

16 BIRTHPLACE OF MOTHER (City) (State or country) Hartford Conn

17 Informant Wilbur S. Bartlett (Relation, if any Father)
(Address) Shrewsbury, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Howard C. Stone
(Signature of Agent of Board of Health or other)
Agent Board of Health July 11, 48
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 10 1948
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)
Multiple skull fractures with brain lacerations sustained in automobile accident

20 Accident, suicide, or homicide (specify) accident
Date of occurrence July 10 19 48
Where did Injury occur? Southboro, Mass
(City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? Public highway (Rt. 85 Southboro)
(Specify type of place)
Manner of Injury Automobile accident
Nature of Injury Fractured Skull, brain lacerations multiple injuries
While at work? Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) E. Allen Gunek, M. D.
(Address) Grafton Mass. Date July 9 1948

22 Mt. View Cemetery, Shrewsbury
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL July 12 1948

23 NAME OF FUNERAL DIRECTOR Howard C. Allen
ADDRESS 653 Main St., Shrewsbury

Received and filed July 13, 1948 19 48
(Registrar)

ORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

100m-(1)-1-45-15510

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

(City or town making return)

STANDARD CERTIFICATE OF DEATH

Registrar's No. 17

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. Latisquama Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Margaret Stewart (nee Dunn)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 29 Bridge St. Marlboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) Rest Home (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elsworth Stewart
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 85 Years Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: at Home

10 Industry or Business:

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

13 NAME OF FATHER Michael Dunn

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Margaret Cawhey

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Mrs Maurice Kirby Elm St marlboro Relation, if any (Sister)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone.
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) July 20 1948 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July (Month) 19 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Nov 47, to July 19 48, I last saw her alive on July 19, 1948, death is said to have occurred on the date stated above, at 3.05 P.M.

Immediate cause of death — Duration IMPORTANT

Chronic Myocarditis — 6 mos.

Due to Cardiac Decompensation — 2 wks.

Due to

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations None

Date of

Of autopsy None

What test confirmed diagnosis? Typical Signs

IMPORTANT

Physician

Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) [illegible] M. D.
(Address) Marlboro Mass Date July 19 48

21 Immaculate Conception Marlboro Mass
Place of Burial, Cremation or Removal (City or Town)
DATE OF BURIAL July 21 1948

22 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed July 21 1948
John J Bakeris
(Registrar)

A TRUE COPY ATTEST:

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

30m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 18

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George Washington Stevens (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Edgewood Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Hospital (Before death) (Specify whether) years months 1 days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): widow

5a If married, widowed, or divorced HUSBAND of Charlotte Carroll (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years 6 Months 7 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Retired carpenter

10 Industry or Business:

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Waterville, Vermont

PARENTS

13 NAME OF FATHER Unknown Stevens

14 BIRTHPLACE OF FATHER (City) (State or country) Cannot be learned

15 MAIDEN NAME OF MOTHER cannot be learned

16 BIRTHPLACE OF MOTHER (City) (State or country) cannot be learned

17 Informant Chester Stevens (Relation, if any son)
(Address) Edgewood Rd. Southboro, Mass.

A TRUE COPY.
ATTEST: Wm. J. Walsh
(Registrar of city or town where death occurred)

DATE FILED August 2, 1948 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 30, 1948 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from July 30, 1948, to July 30, 1948

I last saw him alive on July 30, 1948 death is said to have occurred on the date stated above, at 7:00 p.m.

	Duration
Immediate cause of death: Respiratory failure	
Due to cerebral vascular hemorrhage	4 days
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations none Date of

Of autopsy none

What test confirmed diagnosis? lumbar Puncture

20 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Bruce R. Brown M. D.
(Address) Framingham, Mass Date 7/31/1948

Physician: Underline the cause to which death should be charged statistically.

21 PLACE OF BURIAL, CREMATION OR REMOVAL Sanderson Fairfax VT (Cemetery) (City or Town)
DATE OF BURIAL August 2, 1948 19

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS Framingham, Mass.

Received and filed August 11 1948
(Registrar of City or Town where deceased resided)

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

100m-(f)-1-45-15510

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

(City or town making return)

STANDARD CERTIFICATE OF DEATH

Registrar's No. 19

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southbridge; No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Frank J Martinelli (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) I

(a) Residence. No. 62 East Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) years months days. (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Evangelina B. (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 57 Years 7 Months Days. If less than 1 day Hours Minutes

9 Usual Occupation: Supervisor of Employee Services

10 Industry or Business: Gilchrist Co

11 Social Security No. 021-05-0369

12 BIRTHPLACE (City) (State or country) Southbridge Mass

PARENTS

13 NAME OF FATHER Ciriaco Martinelli

14 BIRTHPLACE OF FATHER (City) (State or country) Italy

15 MAIDEN NAME OF MOTHER Rosanne Ferguson

16 BIRTHPLACE OF MOTHER (City) (State or country) Londonderry Ireland

17 Interment (Address) Mrs Evangelina Martinelli East Main St Southbridge Relation, if any (Wife)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) Aug 6 1948 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Aug (Month) 5 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1946, to Aug 5, 1948

I last saw him alive on Aug 4, 1948, death is said to have occurred on the date stated above, at 5:30 A. M.

	Duration IMPORTANT
Immediate cause of death Uremia	6 wks
Due to Vascular nephritis	2 yrs ?
Due to Essential Hypertension	5 yrs ?
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Date of	
Of autopsy	
What test confirmed diagnosis?	

IMPORTANT Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Hugh Tolman, M. D.
(Address) Framingham Date Aug 6, 1948

21 Burial Southbridge Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Aug 7, 1948

22 NAME OF FUNERAL DIRECTOR John J. Dacey
ADDRESS 95 Main St Southbridge Mass

Received and filed August 6, 1948
Frances E. Fabens (Registrar)

A TRUE COPY ATTEST:

EXTRACTS FROM THE LAWS OF THE COMMONWEALTH OF MASSACHUSETTS GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death . . . Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L., (Tercentenary Edition).

Medical examiners shall make examination upon the view of the dead bodies of only such persons as are supposed to have died by violence. If a medical examiner has notice that there is within his county the body of such a person, he shall forthwith go to the place where the body lies and take charge of the same; . . . —General Laws, Chap. 38, Sec. 6.

No undertaker or other person shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made. . . . Chap. 114, Sec. 46, G. L., (Tercentenary Edition).

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons), thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

Statement of Cause of Death.—Cause of death means the disease, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the occupation had been given up or changed on account of the disease causing death, report the usual occupation prior to illness. If the deceased had retired from business, report the usual occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housework. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as housekeeper—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE Sept 15 1918

DATE OF DISCHARGE Jan 14, 1919

RANK, RATING Sgt.

ORGANIZATION AND OUTFIT 17th Co. Portland Coast Artillery

SERVICE NUMBER 490152

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

50m-(1)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 20

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Southville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Roy Sharrock (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Southville Rd. St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) ✓ (Specify whether) years ✓ months ✓ days. In this community 25 yrs. 2 mos. 2 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of Clara E. Brown (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive 60 years

7 IF STILLBORN, enter that fact here.

8 AGE 63 Years 11 Months 5 Days | If less than 1 day Hours Minutes

9 Usual Occupation: carpenter

10 Industry or Business: House building

11 Social Security No. 030-12-9281

12 BIRTHPLACE (City) (State or country) Vienna Maine

PARENTS

13 NAME OF FATHER John Sharrock

14 BIRTHPLACE OF FATHER (City) Hallowell (State or country) Maine

15 MAIDEN NAME OF MOTHER Elizabeth Allen

16 BIRTHPLACE OF MOTHER (City) Cannot be learned (State or country) Maine

17 Informant Clara E. Sharrock (Address) Southville Rd Southboro Mass Relation, if any wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (R.H.B.) (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) 22 Aug '48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Aug (Month) 20 (Day) 1948 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury

Nature of Injury

While at work? Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date Aug 20 1948

22 Burial Worcester Mass. Place of ~~Burial~~, Cremation ~~or Removal~~. (City or Town)

DATE OF BURIAL Aug 23 1948

23 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro Mass

Received and filed Aug 22 1948

Aug 30/48 To J. P. Stone

Frances Zabriskie R.H.B. (Registrar)

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 21

1 PLACE OF DEATH: (County) Worcester. (City or Town) Southboro No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John F. Mulvey (If deceased is a married, widowed, or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Milford Town Infirmary St. Milford Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) years months 8 days. In this community yrs. mos. 8 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) Mary F. Gray (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 77 Years 11 Months 12 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Laborer (Retired)

10 Industry or Business: Farm Worker

11 Social Security No. None

12 BIRTHPLACE (City) (State or country) Providence Rhode Island

PARENTS

13 NAME OF FATHER: James Mulvey

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER: Mary Moran

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant (Address) Supt. Milford Mass Relation, if any

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health, or other)

Agent Board of Health (Official Designation) Sept 21 48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Sept (Month) 21 (Day) 1948 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably Coronary Sclerosis

20 Accident, suicide, or homicide (specify) .....

Date of occurrence ..... 19.....

Where did injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of injury .....

Nature of injury .....

While at work? ..... Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Walter F. Mulvey, M. D.

(Address) Southborough Date Sept 21 1948

22 St. Mary's Milford Mass Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Sept 24 1948

23 NAME OF FUNERAL DIRECTOR Joseph F. Edwards

ADDRESS 26 Main St. Milford Mass

Received and filed September 22 1948

Frances E. Palmer (Registrar)

Asst Clerk

FORM R-301 A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 45, Section 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-(g)-1-45-15510

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 22

1 PLACE OF DEATH: Worcester (County); Southbornah (City or Town); No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harriet M. Hoare
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. W. Main St. Northboro Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Institution (Before death) years — months — days. (Specify whether) In this community 2 5 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 82 Years 2 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Nurse (Retired)

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country): Cohasset Mass

PARENTS

13 NAME OF FATHER: David G. Hoare

14 BIRTHPLACE OF FATHER (City) (State or country): Cohasset Mass.

15 MAIDEN NAME OF MOTHER: Harriet M. Parker

16 BIRTHPLACE OF MOTHER (City) (State or country): Mass

17 Informant: Mrs. Ethel Bridger (Address) 103 Audale Rd. Baldwinsdale Mass. Relation, if any: Niece

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Shone
(Signature of Agent of Board of Health or other)

Agent, Board of Health Oct 3, '48
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Oct. (Month) 2 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1948, to Oct 1, 1948
I last saw h.. alive on Oct 1-1948, 19..., death is said to have occurred on the date stated above, at 5 a.m.

Duration — IMPORTANT

Immediate cause of death
Hypostatic Pneumonia

Due to Senility

Due to .....

Other conditions (include pregnancy within 8 months of death) Arteriosclerotic Heart Disease — IMPORTANT

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) D. E. Chapman M. D.
(Address) Main St. Hopkinton Mass Date Oct 2 19 48

21 Rural Cemetery Worcester Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL October 4 1948

22 NAME OF FUNERAL DIRECTOR S. Standish Stephenson
ADDRESS 91 Pleasant St. Watertown, Mass

Received and filed Oct 4 1948
Frances E. Parker
(Registrar)

ORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

100m-(1)-1-45-15510

PLACE OF DEATH

1 (County) Worcester

(City or Town) Southboro

No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY

DIVISION OF VITAL STATISTICS

(City or town making return)

STANDARD CERTIFICATE OF DEATH

Registrar's No. 23

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

2 FULL NAME Percy S Creelman

(If deceased is a married, widowed or divorced woman, give also maiden name.)

(a) Residence. No. Baker Rest Home St.

(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution (Before death) years months days. (Specify whether) In this community — yrs. — mos. 8 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of Flora Poitras (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive years

7 IF STILLBORN, enter that fact here.

8 AGE 68 Years 3 Months 19 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired meat cutter

10 Industry or Business: Market

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Bloomington Nova Scotia

PARENTS

13 NAME OF FATHER Charles Gustavus Creelman

14 BIRTHPLACE OF FATHER (City) (State or country) Stewiacke N. S. Cholchester Co.

15 MAIDEN NAME OF MOTHER Ida May Armstrong

16 BIRTHPLACE OF MOTHER (City) (State or country) Bloomington Nova Scotia

17 Informant (Address) Marlboro Old Age Assistance, City Hall Relation, if any ( )

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone

(Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) Oct 23, 48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Oct (Month) 22 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1948, to Oct 22, 1948

I last saw him alive on Oct 22, 1948, death is said to have occurred on the date stated above, at 9.10 P.M.

Immediate cause of death: Sclerotic Heart Disease — Duration IMPORTANT: 1 hrs

Due to Arterio Sclerosis — Duration: years

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations no operation — Date of

Of autopsy none

What test confirmed diagnosis? examination

IMPORTANT

Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Geo W. Smith, M. D.

(Address) Marlboro Date 10/23 1948

21 Rural Worcester

Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Oct 25, 1948 19

22 NAME OF FUNERAL DIRECTOR Sumner E. Grage

ADDRESS Marlboro, Mass.

Received and filed Oct 26 1948

John J. Rabesa (Registrar)

A TRUE COPY ATTEST:

ORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

100m-(f)-1-45-15510

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registrar's No. 34

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town) — No. Lyman St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Patrick M. Salmon (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Lyman St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution _____ (Before death) (Specify whether) years months days. In this community 81 yrs. 4 mos. 11 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of Delia Noonan (Give maiden name of wife in full)
(or) WIFE of _____ (Husband's name in full)

6 Age of husband or wife if alive _____ years

7 IF STILLBORN, enter that fact here.

8 AGE 81 Years 4 Months 11 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired Sup.

10 Industry or Business: Deerfoot Farms

11 Social Security No. none

12 BIRTHPLACE (City) (State or country) Southboro Mass

PARENTS

13 NAME OF FATHER Patrick M. Salmon

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Catherine Burke

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant Eileen Salmon (Address) Lyman St Southboro Relation, if any (daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy F. Stone
(Signature of Agent of Board of Health or other)

Agent. Bd of Health (Official Designation) Nov 2, 1948 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 2 1948 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from June 13, 1948, to Nov 2, 1948,
I last saw h/ alive on Nov 1, 1948, death is said to have occurred on the date stated above, at 3:30 A. M.

	Duration IMPORTANT
Immediate cause of death Arteriosclerotic Heart Disease	yrs
Due to Gen Arteriosclerosis	yrs.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings: Of operations none Date of
Of autopsy none
What test confirmed diagnosis? Phy Exam.

IMPORTANT Physician Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Millard Burke, M. D.
(Address) Marlboro Date 11/2 1948

21 Rural Cemetery Southboro
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL November 4, 1948

22 NAME OF FUNERAL DIRECTOR William M. Tighe
ADDRESS 3 Windsor st Marlboro

Received and filed Nov 3 1948
John J. Rabeni (Registrar)

A TRUE COPY ATTEST:

FORM R-301 A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
STANDARD
CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 23

1 PLACE OF DEATH: Worcester (County)
Southboro (City or Town)
No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Delia Burton (nee Kane)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cedar St. Hopkinton
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) (Specify whether) 5 years months days. In this community 5 yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

5a If married, widowed or divorced HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Henry N. Burton (Husband's name in full)

6 Age of husband or wife if alive ______ years

7 IF STILLBORN, enter that fact here.

8 AGE 92 Years 10 Months Days. If less than 1 day: Hours Minutes

9 Usual Occupation: At Home

10 Industry or Business:

11 Social Security No. none

12 BIRTHPLACE (City) Boston (State or Country) Massachusetts

PARENTS

13 NAME OF FATHER Martin Kane

14 BIRTHPLACE OF FATHER (City) (State or Country) Ireland

15 MAIDEN NAME OF MOTHER Mary Keenan

16 BIRTHPLACE OF MOTHER (City) (State or Country) Ireland

17 Informant Thomas Kelly (Relation, if any) none
(Address) Hopkinton, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:
Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, B of Health (Official Designation) Nov 6, 48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov (Month) 6 (Day) 48 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1948 to Nov 6, 1948
I last saw her alive on Nov 5, 1948, death is said to have occurred on the date stated above, at 2 pm.

Immediate cause of death Hypostatic Pneum. due to Senility

Due to

Due to

Other conditions Arteriosclerosis [illegible]
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Date of
Of autopsy
What test confirmed diagnosis?

Duration
IMPORTANT
IMPORTANT
Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? If so, specify
(Signed) [illegible] M. D.
(Address) Hopkinton Mass Date 1948

21 Holyhood Brookline
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL November 8, 1948

22 NAME OF FUNERAL DIRECTOR J. F. Callanan & Son
ADDRESS Hopkinton Mass.

Received and Filed Nov 8 1948
John J. Rabeni
(Registrar)

N.B. — WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

MARGIN RESERVED FOR BINDING

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100M-7-46-19068

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK -- THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

30m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 26p

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Baby Girl Harris (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Main St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution Hosp. (Before death) (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here. Stillborn

8 AGE ..... Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation:

10 Industry or Business:

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

13 NAME OF FATHER Edward G. Harris

14 BIRTHPLACE OF FATHER (City) (State or country) Boston, Mass.

15 MAIDEN NAME OF MOTHER Shirley Barlow

16 BIRTHPLACE OF MOTHER (City) (State or country) Boston, Mass.

17 Informant (Address) Rev. Edward G. Harris (Relation, if any) father
Southboro

A TRUE COPY.
ATTEST: November 15, 1948 (Registrar of city or town where death occurred)
DATE FILED 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November 13, 1948 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Stillborn, 19..., to ..., 19...
I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at 5:05 A m.

Immediate cause of death	Duration
Hydrocepholus -	
Due to	
Due to	
Other conditions. (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Date of
Of autopsy
What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Joseph C. Merriam, M. D.
(Address) Framingham Mass. Date 11/13 19 48

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cem. Southboro (Cemetery) (City or Town)
DATE OF BURIAL November 15, 1948 19

22 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS Framingham, Mass.

Received and filed Dec 10 19 48
(Registrar of City or Town where deceased resided)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

100m-2-'40-D-729-a

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 26

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. Chestnut Hill Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Clara Bell (Ellis)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(If U. S. War Veteran, specify WAR) —

(a) Residence. No. Lake Delton, St. Wisconsin
(Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution ..... years ..... months ..... days. (Specify whether) In this community yrs. 1 mos. 18 days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of William H. Bell
(Husband's name in full)

6 Age of husband or wife if alive 73 years

7 IF STILLBORN, enter that fact here.

8 AGE 73 Years 3 Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: at Home

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Delton Wisconsin

PARENTS

13 NAME OF FATHER: Ellis

14 BIRTHPLACE OF FATHER (City) (State or country): Ireland

15 MAIDEN NAME OF MOTHER: Unobtainable

16 BIRTHPLACE OF MOTHER (City) (State or country): Unobtainable

17 Informant (Address) Daniel J. Danahy, Southboro, Mass. Relation, if any: (Son in Law)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Finley P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) Nov 15, 1948 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November (Month) 14 (Day) 1948 (Year)

19 I HEREBY CERTIFY. That I attended deceased from October 21, 1948, to November 14, 1948

I last saw her alive on November 14, 1948, death is said to have occurred on the date stated above, at 2.02 p. m.

Immediate cause of death ..... Duration

Cancer of brain and lungs ..... months

Due to .....

Due to .....

Other conditions none
(Include pregnancy within 3 months of death)

IMPORTANT

Major findings:
Of operations none Date of .....
Of autopsy .....
What test confirmed diagnosis? X Ray.

IMPORTANT PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Albert E. LeMaitre M. D.
(Address) Marlboro Date Nov. 14 1948

21 Delton, Cem., Lake Delton, Wis.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov. 17, 1948 19....

22 NAME OF FUNERAL DIRECTOR John P. Rowe
ADDRESS Main St. Marlboro, Mass.

Received and filed Nov 15 1948

John J. Rabeni (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

100m-2-'40-D-729-a

1 PLACE OF DEATH: Worcester (County); Douglas (City or Town); No. Turnpike Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 27

2 FULL NAME. Frances C. Bouchard (Raney) (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Turnpike Road St. (Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of Louis G. Bouchard (Husband's name in full)

6 Age of husband ~~or wife~~ if alive 57 years

7 IF STILLBORN, enter that fact here.

8 AGE 56 Years 7 Months Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Albany N.Y.

PARENTS

13 NAME OF FATHER Raney

14 BIRTHPLACE OF FATHER (City) (State or country) Quebec

15 MAIDEN NAME OF MOTHER Sarah Hogan

16 BIRTHPLACE OF MOTHER (City) (State or country) unknown

17 Informant (Address) Louis G. Bouchard (Husband) Relation, if any
Turnpike Rd, Saylesville Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) Nov. 16 '48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH November (Month) 15 (Day), 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from March 24, 1948, to November 15, 1948

I last saw her alive on November 5, 1948 death is said to have occurred on the date stated above, at 9:00 A. m.

Immediate cause of death — Duration IMPORTANT at death
Coronary Thrombosis

Due to Hypertensive Heart Disease — 1-2 yrs.

Due to

Other conditions Recent Breast Cancer Removed. — 9 mos.
(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma, right breast Date of Apr 48
Of autopsy none
What test confirmed diagnosis? none

IMPORTANT PHYSICIAN: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? no
If so, specify —
(Signed) Timothy P. Stone, M. D.
(Address) Main St. Douglas Date Nov 16 1948

21 Blue Hill Cem., Braintree
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov 18, 1948

22 NAME OF FUNERAL DIRECTOR John D. Rose
ADDRESS Hamilton, Mass.

Received and filed Nov 18 1948
John J. Galeni (Registrar)

FORM R-301 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

100m-(g)-1-45-15510

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 28

1 PLACE OF DEATH
Worcester (County)
Fayville (City or Town)
No. Oakhill Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Condelia (Boucher) Dagenais
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN - IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Oakhill Rd St. Fayville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community 10 yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

5a If married, widowed, or divorced
HUSBAND of .....
(or) WIFE of John Boucher (Father)
(Give maiden name of wife in full)
(Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 93 Years 5 Months 27 Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Housewife

10 Industry or Business: .....

11 Social Security No. .....

12 BIRTHPLACE (City) (State or country) Unity New Hampshire

PARENTS

13 NAME OF FATHER Leon Dagenais (Husband)

14 BIRTHPLACE OF FATHER (City) (State or country) Canada

15 MAIDEN NAME OF MOTHER Ester Peltier

16 BIRTHPLACE OF MOTHER (City) (State or country) Canada

17 Informant Mrs. Denise Jackman (Address) (Relation, if any Daughter)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone.
(Signature of Agent of Board of Health or other)

Agent Bd of Health 11/26/48
(Official Designation) (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov (Month) 24 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1948, to Nov 24, 1948

I last saw her alive on Nov 23, 1948, death is said to have occurred on the date stated above, at 9:45 a m.

Immediate cause of death — Duration
Cardiac Decompensation — 8 weeks
IMPORTANT

Due to
Arteriosclerotic Heart Disease — 1 yr.

Due to .....

Other conditions (Include pregnancy within 3 months of death)
IMPORTANT

Major findings:
Of operations ..... Date of .....
Of autopsy .....
What test confirmed diagnosis? .....

Physician
Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? If so, specify ..... No

(Signed) J. J. Carmichael M. D.
(Address) 115 Hudson Ave Framingham Date Nov 26 1948

21 Rural Cemetery South Lee, Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Nov 27 1948

22 NAME OF FUNERAL DIRECTOR Seymour O. Wood
ADDRESS 15 Church St. Hopkinton Mass

Received and filed Nov 27 1948
John J. Radem (Registrar)

FORM R-301

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 46, Sec. 10, requires physicians to insert a recital to that effect.

100m-(1)-1-45-15510

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) _____

Registrar's No. 29

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas F. Connors (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) _____

(a) Residence. No. East Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution _____ (Before death) (Specify whether) years months days. In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Margaret R Harris (Give maiden name of wife in full)
(or) WIFE of 58 (Husband's name in full)

6 Age of husband or wife if alive _____ years

7 IF STILLBORN, enter that fact here.

8 AGE 71 Years ___ Months ___ Days | If less than 1 day ___ Hours ___ Minutes

9 Usual Occupation: Guard

10 Industry or Business: Bay State Factory Westboro

11 Social Security No. 023-12-8760

12 BIRTHPLACE (City) (State or country) Hudson Mass

PARENTS

13 NAME OF FATHER Thomas Connors

14 BIRTHPLACE OF FATHER (City) (State or country) Ireland

15 MAIDEN NAME OF MOTHER Ellen Comer

16 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

17 Informant Margaret R. Connors (Address) East Main St Southboro Relation, if any (Wife)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Lino My P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) 29 Nov '48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov (Month) 29 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1948, to Nov 29, 1948
I last saw h in alive on Nov 29, 1948 death is said to have occurred on the date stated above, at 2.15 P.M.

Immediate cause of death: Bronchial pneumonia
Heart failure — Duration IMPORTANT: 3 days

Due to: Carcinoma of Rectum — 6 mo

Due to: _____

Other conditions (Include pregnancy within 3 months of death): _____

Major findings: Of operations: Carcinoma of Rectum — Date of _____

Of autopsy: none

What test confirmed diagnosis? Examination

IMPORTANT — Physician — Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) C. F. Smith, M. D.
(Address) Marlboro Date 11/29 1948

21 St Michael Hudson Mass
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec 1st 1948

22 NAME OF FUNERAL DIRECTOR Wm M. Tighe
ADDRESS Marlboro Mass

Received and filed Nov. 30 1948
John J. Baker
(Registrar)

A TRUE COPY ATTEST:

FORM R-301

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions and extracts from the laws on back of certificate.

If deceased was a U. S. War Veteran, G. L., Chap. 48, Sec. 10, requires physicians to insert a recital to that effect.

MARGIN RESERVED FOR BINDING

100m-(f)-1-45-15510

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) _____

Registrar's No. 30

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro

No. Baker Red Stone St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Celia M. Taylor (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 87 Pleasant St. Worcester (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or Institution _____ years _____ months _____ days. (Before death) (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE (write the word) MARRIED WIDOWED or DIVORCED
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of Warren Taylor. (Give maiden name of wife in full) (Husband's name in full)

6 Age of husband or wife if alive _____ years

7 IF STILLBORN, enter that fact here.

8 AGE 70 Years ____ Months ____ Days | If less than 1 day ____ Hours ____ Minutes

9 Usual Occupation: Cook (Retired)

10 Industry or Business: Hotel Hospital

11 Social Security No. _____

12 BIRTHPLACE (City) (State or country) Machias Me

PARENTS

13 NAME OF FATHER John P. McKenzie

14 BIRTHPLACE OF FATHER (City) (State or country) Machias Me

15 MAIDEN NAME OF MOTHER Amelia Crocker

16 BIRTHPLACE OF MOTHER (City) (State or country) _____

17 Informant Wesley Taylor (Address) 26 Houghton St. Hudson Relation, if any (Son)

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) Dec 2 48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Nov (Month) 30 (Day) 1948 (Year)

19 I HEREBY CERTIFY, That I attended deceased from Jan, 19 48, to Nov 30, 19 48

I last saw h alive on Nov 30, 19 48, death is said to have occurred on the date stated above, at 9:15 M.

Immediate cause of death Bronchopneumonia — Duration IMPORTANT 7 day

Due to Acute Bronchitis — 1 week

Due to _____

Other conditions Chronic Arthritis — 3

(Include pregnancy within 3 months of death) Hypertrophy Prostate — IMPORTANT ?

Major findings: Of operations _____ Date of _____

Of autopsy _____

What test confirmed diagnosis? Clinical

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) J. J. Cunningham, M. D.

(Address) Hyde Park Mass Date Dec 2 1948

21 Maplewood Marlboro
Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Dec 3 1948

22 NAME OF FUNERAL DIRECTOR John J. Brown

ADDRESS 95 Main St Marlboro

Received and filed Dec 3 1948

Thomas A Baldwin
(Registrar)

A TRUE COPY ATTEST:

Post Clerk

FORM R-305

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-10-39. No. 8427-g

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 30

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lizzie M. Curtis
(If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Conners Rest Home, East Main St. Southboro
(Usual place of abode) (If nonresident, give city or town and state)

Length of stay: In hospital or institution..... years months days. In this community 50 yrs. mos. days.
(Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

6 Age of husband or wife if alive..... years

7 IF STILLBORN, enter that fact here.

8 AGE 90 Years 5 Months 10 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Box Maker Retired

10 Industry or Business: Dennison Mfg. Co.

11 Social Security No.....

12 BIRTHPLACE (City) (State or country) Bowdoinham Maine

PARENTS

13 NAME OF FATHER William Curtis

14 BIRTHPLACE OF FATHER (City) (State or country) Maine

15 MAIDEN NAME OF MOTHER Cannot learn

16 BIRTHPLACE OF MOTHER (City) (State or country) Cannot learn

17 Informant John Morse (Address) Main S., Ashland — Relation, if any Nephew

A TRUE COPY.
ATTEST: Wm. A. Walsh
(Registrar of city or town where death occurred)

DATE FILED December 9, 1948

MEDICAL CERTIFICATE OF DEATH

19 DATE OF DEATH December 8, 1948
(Month) (Day) (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture left Femur
General Arteriosclerosis

20 Accident, suicide, or homicide (specify) Accident
Date of occurrence Oct. 21, 1948 19
Where did Injury occur? Southboro, Mass.
(City or town and State)

Did injury occur in or about the home, on farm, in industrial place, or in public place? Home
(Specify type of place)

Manner of Injury Fall

Nature of Injury Fracture Left Femur

While at work? no Was there an autopsy? View

21 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....

(Signed) Michael F. Burke M. D.
(Address) Framingham, Mass. Date 12-8 19 48

22 Edgell Grove, Framingham, Mass.
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL Dec. 9, 1948 19

23 NAME OF FUNERAL DIRECTOR Robert K. Wadsworth
ADDRESS Framingham, Mass.

Received and filed Jan. 3 19 49
John L. Baker
(Registrar of City or Town where deceased resided)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths recorded during the previous month which occurred in your city or town in case the deceased resided in another city or town at the time of death should be made forthwith and transmitted on Form R-302 to the clerk of the city or town in which the deceased resided. (See Chap. 46, Sec. 12, G. L.)

50m-(b)-6-44-14607

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS
COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 300

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Florence Eames Smith (If deceased is a married, widowed or divorced woman, give also maiden name.) (If U. S. War Veteran, specify WAR)

(a) Residence. No. Marlboro Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution Hospital years months 12 days. (Before death) (Specify whether) In this community yrs. mos. days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed, or divorced HUSBAND of (Give maiden name of wife in full) (or) WIFE of Ralph E. Smith (Husband's name in full)

6 Age of husband or wife if alive 59 years

7 IF STILLBORN, enter that fact here.

8 AGE 59 Years 3 Months 7 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Housewife

10 Industry or Business: At home

11 Social Security No.

12 BIRTHPLACE (City) (State or country) Woburn, Mass.

PARENTS

13 NAME OF FATHER Newal Eames

14 BIRTHPLACE OF FATHER (City) (State or country) New York

15 MAIDEN NAME OF MOTHER Martha Morse

16 BIRTHPLACE OF MOTHER (City) (State or country) Holliston, Mass.

17 Informant (Address) Mr. Ralph E. Smith Marlboro Rd., Southboro (Relation, if any) Husband

A TRUE COPY.

ATTEST: W. A. Walsh (Registrar of city or town where death occurred)

DATE FILED December 15, 1948 19

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH December 12, 1948 (Month) (Day) (Year)

19 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1948, to Dec. 12, 1948

I last saw her alive on Dec. 12, 1948, death is said to have occurred on the date stated above, at 5:30 A. m.

Immediate cause of death	Duration
Hypostatic pneumonia	4 days
Due to Cerebral thrombosis	1 wk.
Due to Hypertension	

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Date of

Of autopsy

What test confirmed diagnosis?

Physician: Underline the cause to which death should be charged statistically.

20 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Edward J. DeNicolais, M. D.

(Address) Framingham, Mass. Date 12-13 19 48

21 PLACE OF BURIAL, CREMATION OR REMOVAL Rural Cemetery (Cemetery) Southboro (City or Town)

DATE OF BURIAL December 14, 1948 19

22 NAME OF FUNERAL DIRECTOR John L. Norton, Sr.

ADDRESS Framingham, Mass.

Received and filed Jan 3 1949

John J. Babineau (Registrar of City or Town where deceased resided)

FORM R-303-A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 31

1 PLACE OF DEATH
(County) Middlesex
(City or Town) Shrewsbury
No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Delina Doucette DELINA DOUCETTE
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Medina St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution ..... years ..... months ..... days. In this community ..... yrs. ..... mos. ..... days.
(Before death) (Specify whether)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) CALIXTE Doucette (Give maiden name of wife in full)
CALIXTE (Husband's name in full)

6 Age of husband or wife if alive ..... years

7 IF STILLBORN, enter that fact here.

8 AGE 78 Years ..... Months ..... Days | If less than 1 day ..... Hours ..... Minutes

9 Usual Occupation: Homemaker

10 Industry or Business:

11 Social Security No. —

12 BIRTHPLACE (City) (State or country) St Hyacinthe P.Q.

PARENTS

13 NAME OF FATHER: Joseph Brissonette

14 BIRTHPLACE OF FATHER (City) St Hyacinthe (State or country) P.Q.

15 MAIDEN NAME OF MOTHER: not known

16 BIRTHPLACE OF MOTHER (City) St. Hyacinthe (State or country) P.Q.

17 Informant (Address) Calixte Elvia Doucette (Relation, if any) Son

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent, Bd of Health
(Official Designation)
Dec 17 '48
(Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH Dec (Month) 16 (Day) 1948 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary Thrombosis

20 Accident, suicide, or homicide (specify)
Date of occurrence 19
Where did Injury occur? (City or town and State)
Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)
Manner of Injury
Nature of Injury
While at work? Was there an autopsy? No

21 Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) Walter F. Murphy, M. D.
(Address) Westboro Date Dec 16 1948

22 St. Mary's Cemetery Shrewsbury
Place of Burial, Cremation or Removal. (City or Town)
DATE OF BURIAL December 18 1948

23 NAME OF FUNERAL DIRECTOR Henry A. Hastings
ADDRESS 93 Broad St. Shrewsbury

Received and filed Dec. 18 1948
John J. Kaleva
(Registrar)

FORM R-303-A

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G. L. Chap. 46, Section 10, requires physicians to insert a recital to that effect

MARGIN RESERVED FOR BINDING

50m-(f)-6-43-12056

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 32

1 PLACE OF DEATH: Worcester (County) Southbord (City or Town) No. Southville RD St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George H Woodard (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN—IMPORTANT (Was deceased a U. S. War Veteran, If so specify WAR)

(a) Residence. No. Southville RD St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In hospital or institution (Before death) — (Specify whether) years — months — days. In this community 38 yrs. — mos. — days.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Married

5a If married, widowed or divorced HUSBAND of Josephine C. Tinnon (Give maiden name of wife in full) (or) WIFE of (Husband's name in full)

6 Age of husband or wife if alive ... years

7 IF STILLBORN, enter that fact here.

8 AGE 70 Years 7 Months 2 Days | If less than 1 day Hours Minutes

9 Usual Occupation: Retired

10 Industry or Business: Railroad Conductor

11 Social Security No. 114-09-3805

12 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

13 NAME OF FATHER: Francis D. Woodard

14 BIRTHPLACE OF FATHER (City) (State or country) Boston Mass.

15 MAIDEN NAME OF MOTHER: Ruth Aliff

16 BIRTHPLACE OF MOTHER (City) (State or country) Boston Mass.

17 Informant (Address) Mrs. Josephine C. Woodard Southville Rd Southboro Mass. Relation, if any Wife

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jimothy P. Stone (Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) Dec 27, '48 (Date of Issue of Permit)

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH: Dec (Month) 24 (Day) 1948 (Year)

19 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary thrombosis

20 Accident, suicide, or homicide (specify)

Date of occurrence 19

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury

Nature of Injury

While at work? Was there an autopsy? no

21 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter J Woodman, M. D.

(Address) Westborough Date Dec 24 1948

22 Mt. Pleasant Arlington Mass. Place of Burial, Cremation or Removal. (City or Town)

DATE OF BURIAL Dec. 27 1948

23 NAME OF FUNERAL DIRECTOR Irvine H. Harper

ADDRESS 62 N. Main St. Hopkinton Mass.

Received and filed Dec 28 19 48

Frances E Rebarer (Registrar)

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 1

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro; No. Baker Rest Home; St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Eliza V. Hankard (ELIZA V. HANKARD) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 329 Maple St. Marlboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death .....years.....months.....days. In place of residence .....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: (Month) Jan (Day) 11 (Year) 1949

4 I HEREBY CERTIFY, That I attended deceased from April, 1948, to Jan 11, 1949. I last saw h[er] alive on Jan 11, 1949. death is said to have occurred on the date stated above, at 9.45 p.m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Diffuse arterial Sclerosis — 1 yr.

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations: None

Date of operation: None Was autopsy performed? None

What test confirmed diagnosis? Physical Signs

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John J. Collins M. D.

(Address) Marlboro Mass Date Jan 12 1949

6 Immaculate Conception Marlboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Jan 14, 1949

7 NAME OF FUNERAL DIRECTOR John J. Brown

ADDRESS 73 W. Main St. Marlboro

Received and filed January 14 1949

Edward A. Adams (Registrar)

Assist Clerk

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 76 Years .....Months .....Days. If under 24 hours .....Hours .....Minutes

13 Usual Occupation Retired Shoe Stitcher (Kind of work done during most of working life)

14 Industry or Business: Center Shoe Co

15 Social Security No.

16 BIRTHPLACE (City) Marlboro, (State or country) Mass

PARENTS

17 NAME OF FATHER Wm Hankard

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary Barry

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Miss Frances Hankard 329 Maple St Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) Jan 13 '49 (Date of Issue of Permit)

100M-(D)-10-48-24858

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 11

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary M. Hempel (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Learned St., Southboro St. (Fayville) Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1/3 days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 16, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1949, to Jan. 16, 1949

I last saw her alive on Jan. 16, 1949 death is said to have occurred on the date stated above, at 6:15 P m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Subarachnoid Hemorrhage

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? Bloody Spinal Fluid

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Theodore S. Golden M. D.

(Address) Framingham Date 1/16/ 1949

6 Rural Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 19, 1949

7 NAME OF FUNERAL DIRECTOR Wm. M. Tighe

ADDRESS Marlboro, Mass.

Received and filed Feb 8 1949

Frances E Roberts (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 11 Years 3 Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: School Student (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Marlboro, Mass. (State or country)

PARENTS

17 NAME OF FATHER Carl W. Hempel

18 BIRTHPLACE OF FATHER (City) Athol, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Mary Legere

20 BIRTHPLACE OF MOTHER (City) Cape Britton (State or country) Nova Scotia

21 Informant Carl W. Hempel
(Address) Fayville, Mass.

A TRUE COPY
ATTEST: ..... (Registrar of City or Town where death occurred)

DATE FILED Jan. 19, 1949

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 3

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Linda Mary (Bushing) Ward (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Balser Rest Home (Usual place of abode) St. Southboro, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 ..... days. In place of residence 1 years 4 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 23, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1949, to Jan. 23, 1949

I last saw her alive on Jan. 23, 1949, death is said to have occurred on the date stated above, at 5 P.M. m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Chronic arteriosclerotic heart disease

ANTECEDENT CAUSES Due To (b) Myocarditis

Due To (c)

OTHER SIGNIFICANT CONDITIONS Hypertension

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?..... If so, specify.....

(Signed) J. F. Annunziata M. D.

(Address) Hopkinton, Mass. Date 1/24/49

6 Evergreen Cem. Hopkinton, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL January 25, 1949

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Cotting Ave., Marlboro, Mass.

Received and filed 19 49

Frances E Roberts

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of Eugene Ward (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 1 Months 16 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: At home (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Dublin, Nova Scotia (State or country)

PARENTS

17 NAME OF FATHER George Bushing

18 BIRTHPLACE OF FATHER (City) Dublin, Nova Scotia (State or country)

19 MAIDEN NAME OF MOTHER Suzanne Sperry

20 BIRTHPLACE OF MOTHER (City) Dublin, Nova Scotia (State or country)

21 Informant Mrs. Henry Brown (Address) 154 Hildreth St., Marlboro

A TRUE COPY

ATTEST: .....

(Registrar of City or Town where death occurred)

DATE FILED January 26, 1949

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Registered No. 10 4

1 PLACE OF DEATH: Worcester (County); Westboro (City or Town)

Westborough (City or town making return)

No. Houghton Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice G. Baker (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Wood St. Southville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 8 days. In place of residence 30 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 30, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1947, to January 30, 1949

I last saw her alive on Jan. 30, 1949, death is said to have occurred on the date stated above, at 11.10 p.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Broncho pneumonia	6 days
ANTE CEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS arterio sclerosis chronic? myocarditis chronic	?

Major findings: Of operations none

Date of operation none Was autopsy performed?

What test confirmed diagnosis? Physical examination

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Roland S. Newton, M. D.

(Address) Westboro Date 1/31 1949

6 Glenwood, Lebanon, New Hampshire
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Feb. 3, 1949

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed Feb. 11 1949

John J. Baker
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
female	white	single

10a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 88 Years 5 Months 4 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Nurse Retired (Kind of work done during most of working life)

14 Industry or Business: Private nursing

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Lebanon New Hampshire

PARENTS

17 NAME OF FATHER Joel Baker

18 BIRTHPLACE OF FATHER (City) (State or country) Lebanon New Hampshire

19 MAIDEN NAME OF MOTHER Josephine Boardman

20 BIRTHPLACE OF MOTHER (City) (State or country) Rutland Vermont

21 Informant Mr. George N. Miller
(Address) 3 Robinhood St., Dorchester Mass.

A TRUE COPY. ATTEST: Ronald A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED Feb. 1 1949

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough
(City or town making return)

Registered No. 9 5 *

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice M. Coggeshall
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Central St. Fayville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death - years 1 months 24 days. In place of residence years 1 months 24 days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Jan. 31, 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1948, to Jan. 31, 1949

I last saw her alive on Jan. 30, 1949, death is said to have occurred on the date stated above, at 2.30 p. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocardial degeneration	weeks
ANTE CEDENT CAUSES (b) Due To Generalized Arteriosclerosis	years
(c) Due To	
OTHER SIGNIFICANT CONDITIONS Senile Psychosis simple deterioration	2 mo.

Major findings:
Of operations.....
Date of operation..... Was autopsy performed?.....
What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Marie L. Madi, M. D.
(Address) Westborough Date 1-31 1949

6 Oakland Cem., Providence, R. I.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Feb. 3, 1949

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Cotting Ave., Marlboro, Mass.

Received and filed Feb 11, 1949
Frances E. Roberts
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Joseph Coggeshall
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 4 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Warwick, Rhode Island

PARENTS

17 NAME OF FATHER Willard M. Briggs

18 BIRTHPLACE OF FATHER (City) (State or country) cannot be learned

19 MAIDEN NAME OF MOTHER Nancy Lockwood

20 BIRTHPLACE OF MOTHER (City) (State or country) Warwick, Rhode Island

21 Informant (Address) Westborough State Hospital records

A TRUE COPY
ATTEST: Ernest C. Dunne
(Registrar of City or Town where death occurred)

DATE FILED Feb. 2, 49

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50m-(g)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 6

PLACE OF DEATH

1 Worcester (County)
Southboro (City or Town)
No. Newton St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Henry R. Lincoln
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR).....

(a) Residence. No. Newton St. St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence 55 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 16 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary Sclerosis
Cerebral Hemorrhage

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur?.....
(City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? .....
(Specify type of place)

Manner of Injury .....
(How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Walter F Tenbusch, M. D.

(Address) Westborough Date Feb 16 1949

7 Rural Southboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Feb. 18 1949

8 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS 15-21 Cotting Ave., Southboro Marlboro

Received and filed February 18 1949

John J. Sabens (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX Male

10 COLOR OR RACE White

11 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

11a If married, widowed, or divorced HUSBAND of Grace M. Hawkins
(Give maiden name of wife in full)

(or) WIFE of.....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 71 Years 2 Months 16 Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Farmer
(Kind of work done during most of working life)

15 Industry or Business: General Farming

16 Social Security No.....

17 BIRTHPLACE (City) Bradford Co.
(State or country)

PARENTS

18 NAME OF FATHER Richard M. Lincoln

19 BIRTHPLACE OF FATHER (City) Boston
(State or country) Mass.

20 MAIDEN NAME OF MOTHER Mabel V Murray

21 BIRTHPLACE OF MOTHER (City) , ,
(State or country) Missouri

22 Informant Grace M. Lincoln
(Address) Newton St., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health Feb 17, 1949
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 7

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emily Armstrong Levy
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Edgewood Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 2 years 6 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH February 28, 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1949 to Feb. 28, 1949

I last saw her alive on Feb. 28, 1949; death is said to have occurred on the date stated above, at 10:15 P.M.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Hypertensive heart disease	?
ANTECEDENT CAUSES Due To (b) Hypertension and Arteriosclerosis	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations

Date of operation ..... Was autopsy performed? no

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) H.M. Levenson, M. D.

(Address) Framingham Mass. Date 3/1/49 19

6 Maplewood Windsor, Nova Scotia
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 4, 1949 19

7 NAME OF FUNERAL DIRECTOR Frederick A. Cookson

ADDRESS Framingham, Mass.

Received and filed March 10 1949

Frances E. Rahem
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widow

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Freeman J. Levy (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 4 Months 23 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Sherwood Nova Scotia, Canada

PARENTS

17 NAME OF FATHER Elisha Armstrong

18 BIRTHPLACE OF FATHER (City) (State or country) Sherwood, Nova Scotia

19 MAIDEN NAME OF MOTHER Jane Levy

20 BIRTHPLACE OF MOTHER (City) (State or country) Sherwood, Nova Scotia

21 Informant Willard Armstrong
(Address) 33 Webster St., Framingham

A TRUE COPY
ATTEST: Wm. F. Walsh
(Registrar of City or Town where death occurred)

DATE FILED 3/2/49 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK. — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Boston (City or town making return)

Registered No. 1858 7a

1 PLACE OF DEATH: Suffolk (County); Boston (City or Town)

No. Little Sisters of the Poor St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Patrick J Lane (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. East Main St. Southboro Mass (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death 6 months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 1/49 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 2, 1948, to March 1, 1949

I last saw him alive on Feb. 27, 1949, death is said to have occurred on the date stated above, at 4 A m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	INTERVAL BETWEEN ONSET AND DEATH
Acute cardiac failure	Few Days
ANTECEDENT CAUSES Due To (b) Arterio sclerotic heart	Few Mos.
Due To (c) Arterio sclerosis old age	Few Yrs
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations

Date of operation ..... Was autopsy performed? No

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) E H L Harnett, M. D.

(Address) Boston Mass. Date 3-1 1949

6 Rural Cem-Southboro Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 3/49 19

7 NAME OF FUNERAL DIRECTOR J J Brown

ADDRESS Marlboro Mass.

Received and filed April 15 1949

John L. Roberts
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 11 Months 16 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

17 NAME OF FATHER John Lane

18 BIRTHPLACE OF FATHER (City) (State or country) Boston Mass.

19 MAIDEN NAME OF MOTHER Anne Denehy

20 BIRTHPLACE OF MOTHER (City) (State or country) BostonMass

21 Informant A B Mattioli
(Address)

A TRUE COPY.
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED March 4/49 19

FORM R-301A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 8

1 PLACE OF DEATH: Worcester (County) — Southboro (City or Town)

No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Bertha Elizabeth (Courtellotte) Parmenter (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Dudley St. Marlboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 50 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Mar (Month) 3 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1949 to Mar 3, 1949

I last saw h.. alive on Mar 2, 1949 death is said to have occurred on the date stated above, at 4.50 a.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary occlusion	10 min
ANTECEDENT CAUSES Due To (b)	arteriosclerosis	5 yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS	Arthritis	10 yrs

Major findings: Of operations: none

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) C. W. Smith, M. D.

(Address) Southboro Date 3/4 1949

6 Pine Grove Spencer
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 7, 1949

7 NAME OF FUNERAL DIRECTOR Clymer L. Gage

ADDRESS 15-21 Boiling Ave., Marlboro

Received and filed March 7 1949

Frances E. Roberts asst
(Registrar)

100M-(D)-10-48-24658

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Divorced

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of George Parmenter
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years 4 Months 2 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired housewife
(Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Spencer
(State or country) Mass.

PARENTS

17 NAME OF FATHER Asa Courtellotte

18 BIRTHPLACE OF FATHER (City) Greenwich Village
(State or country) Mass.

19 MAIDEN NAME OF MOTHER Hannah Maria Berry

20 BIRTHPLACE OF MOTHER (City) North Oxford
(State or country) Mass.

21 Informant Mrs. Fred Fuller, (Sister)
(Address) Dudley St., Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent, Bd of Health Mar 4 49
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 9

1 PLACE OF DEATH
Middlesex (County)
Framingham (City or Town)
No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mae I. Varney (Hatch)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Marlboro Road St. Marlboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence ..... years ..... months ..... days.

In Fram. 49 yrs.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 22, 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 42, 19..., to March 22, 1949

I last saw her alive on March 21, 1949, death is said to have occurred on the date stated above, at 8:00A. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cardiac Decompensation	6 mos.
ANTECEDENT CAUSES Due To (b) Essential Hypertension	10yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations

Date of operation ..... Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) T. J. Carnicelli, M. D.
(Address) 118 Union Ave. Date 3/24/49 19...

6 Maple Cemetery, Lincoln, VT.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 26, 1949

7 NAME OF FUNERAL DIRECTOR Cookson Funeral Home
ADDRESS Framingham, Mass.

Received and filed March 24 1949
John J. Baker
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Harley Sayles Varney (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years 7 Months 8 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Lewis, N.Y.

PARENTS

17 NAME OF FATHER Isaac W. Hatch

18 BIRTHPLACE OF FATHER (City) Panton, Vermont (State or country)

19 MAIDEN NAME OF MOTHER Ann Matthews

20 BIRTHPLACE OF MOTHER (City) Panton, Vermont (State or country)

21 Informant Lyle A. Varney
(Address) Marlboro Rd., Marlboro, Mass.

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED ..... 19...

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Marlborough
(City or town making return)

Registered No. 70 9a

1 PLACE OF DEATH: Middlesex (County); ,arlborough (City or Town); No. Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME George W. Baker (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Marlboro Road St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death.....years.....months.....days. In place of residence 6 years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 2, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary insuffiency mycardial fibrous and generalized arterio-sclerosis

5 Accident, suicide, or homicide (specify).....

Date and hour of injury.....19.....

Where did Injury occur?..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? .....Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) N. John Colombo M. D.

(Address) Hudson, Mass Date 4-3-49

7 Maplewood Cem. Marlborough
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 5, 1949

8 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Marlborough, Mass

Received and filed May 12 1949

Francis E Raheem
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Married

11a If married, widowed, or divorced
HUSBAND of Effie Randall
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 71 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

14 Usual Occupation: Stock man Cutting Room
(Kind of work done during most of working life)

15 Industry or Business: shoe manufacturing

16 Social Security No. 017-05-5354

17 BIRTHPLACE (City) (State or country) Marlborough, Mass

PARENTS

18 NAME OF FATHER Thomas Baker

19 BIRTHPLACE OF FATHER (City) (State or country) Ireland

20 MAIDEN NAME OF MOTHER Bessie Malloy

21 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

22 Informant .....
(Address) Marlborough, Mass

A TRUE COPY. F. J. Bertrand
ATTEST: .....
(Registrar of City or Town where death occurred)

April 8, 1949
DATE FILED .....19.....

FORM R-301A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 10

1 PLACE OF DEATH: (County) Worcester; (City or Town) Southboro

No. Baker Rest Home St. Southboro (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Michael J. Lynch (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) none

(a) Residence. No. 144 Chestnut St St. Marlboro Mass (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 21 days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April (Month) 5 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Mar 29 1949 to April 5 1949

I last saw h[illegible] alive on Apr. 5 1949, death is said to have occurred on the date stated above, at 6.45 A.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma rectosigmoid	2yrs.
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations None

Date of operation None Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) John J. Lebote M. D.

(Address) Marlboro, Mass Date Apr. 5 1949

Immaculate Conception Marlboro (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL April 7 1949

7 NAME OF FUNERAL DIRECTOR William M Tighe

ADDRESS Marlboro Mass

Received and filed April 6 1949

John J Rabbett (Registrar)

100M-(D)-10-48-24858

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of Sarah E McNally (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Yard Man (Kind of work done during most of working life)

14 Industry or Business: Boston Elevator

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Marlboro Mass

PARENTS

17 NAME OF FATHER Michael Lynch

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Nora Sweeney

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Myron Lynch 144 Chestnut St Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Bd Health (Official Designation) 4/6/49 (Date of Issue of Permit)

FORM R-301A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 11

PLACE OF DEATH
1 Worcester (County)
Southboro
Worcester (City or Town)

No. Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lora Isabelle (Howard) Newton
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Main St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 58 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April (Month) 14 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1949 to Apr 14, 1949
I last saw her alive on April 14, 1949, death is said to have occurred on the date stated above, at 11:30 P m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) acute dilitation heart

ANTECEDENT CAUSES Due To (b) myocarditis and

Due To (c) nephritis

OTHER SIGNIFICANT CONDITIONS senility — hemeplegia

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? no

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) J. D. Hable, M. D.
(Address) 42 W. main St Marlboro Date 4/15 1949

6 Rural Place of Burial or Cremation, Southboro (City or Town)
DATE OF BURIAL April 17, 1949

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS 15 Cotting Ave., Marlboro Mass.

Received and filed April 18 1949
Walter A Roberts
(Registrar) asst Clk

100M-(D)-10-48-24658

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female | 9 COLOR OR RACE White | 10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Albro W. Newton
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 4 Months 16 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. .....

16 BIRTHPLACE (City) Winthrop
(State or country) Mass

PARENTS

17 NAME OF FATHER Isaac M. Howard

18 BIRTHPLACE OF FATHER (City) England
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Belcher

20 BIRTHPLACE OF MOTHER (City) Winthrop
(State or country) Mass.

21 Informant Fay Howard C. Newton
(Address) Wellesley Hills Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Linda P. Stone
(Signature of Agent of Board of Health or other)

Agent, Board of Health
(Official Designation)

April 16, 1949
(Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50m-(g)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 12

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Baker Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Richard McSweeney (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Home St. Marlboro (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April 15 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumably
Coronary thrombosis

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19 .....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? No

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter F Mahoney, M. D.

(Address) Westborough Date April 16 1949

Immaculate Conception Marlboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 20 1949

8 NAME OF FUNERAL DIRECTOR John J Power

ADDRESS 96 Williams St Marlboro

Received and filed April 19 1949

John J Baker (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Female

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 77 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: ..... (Kind of work done during most of working life)

15 Industry or Business: .....

16 Social Security No. .....

17 BIRTHPLACE (City) Marlboro (State or country) Mass

PARENTS

18 NAME OF FATHER Mc Sweeney

19 BIRTHPLACE OF FATHER (City) ..... (State or country) Ireland

20 MAIDEN NAME OF MOTHER Johanna Barry

21 BIRTHPLACE OF MOTHER (City) ..... (State or country) Ireland

22 Informant Mrs Thomas Callahan
(Address) Greendale Ave Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health April 18 1949
(Official Designation) (Date of Issue of Permit)

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50m-(g)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 13

1 PLACE OF DEATH: Worcester (County) Southbero (City or Town) No. Marlboro Rd Southbero St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

PHYSICIAN — IMPORTANT

2 FULL NAME Louis J. Gratton (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Winchester St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 50 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: April 28 (Month) (Day) 1949 (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Injuries received from auto. Confirmed fract left leg and abdominal injuries - hemorrhage shock - exposure

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury about 1 A M April 28 19 49

Where did Injury occur? Southborough Mass (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Highway (Specify type of place)

Manner of Injury Hit by passing automobile (How did injury occur?)

Nature of Injury Fract femur - hemorrhage - Shock

While at work? no Was autopsy performed? no

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F Mahoney M. D.

(Address) Westborough Date April 28 19 49

7 Rural Southbero Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL April 30 1949

8 NAME OF FUNERAL DIRECTOR William M Tighe

ADDRESS Marlboro Mass

Received and filed April 30 19 49

Frances E Roberts (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: Male

10 COLOR OR RACE: White

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Divorced

11a If married, widowed, or divorced HUSBAND of Miralda Marchand (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 66 Years 4 Months Days | If under 24 hours Hours Minutes

14 Usual Occupation: Janitor (Kind of work done during most of working life)

15 Industry or Business: Machine Shops

16 Social Security No. 024-05-8968

17 BIRTHPLACE (City) (State or country) Ireland

PARENTS

18 NAME OF FATHER Louis Gratton

19 BIRTHPLACE OF FATHER (City) (State or country) Ireland

20 MAIDEN NAME OF MOTHER Catherine Sullivan

21 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

22 Informant (Address) C. Joseph Gratton Winchester ST Southbero

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) April 28, 1949 (Date of Issue of Permit)

724 m

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, and complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 14

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. 10 Marlboro Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Thomas Lowe
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. 10 Marlboro Road St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 3 years 6 months - days. In place of residence 3 years 6 months - days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: May (Month) 31st, (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from 1-19-49, 19..., to 5-31-49, 19...

I last saw him alive on 5-31-49, 19..., death is said to have occurred on the date stated above, at 8:30 P. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary Thrombosis	5 days
ANTECEDENT CAUSES Due To (b)	Cachexia	4 months
Due To (c)	Cancer Stomach Abdominal Carcinomatosis	2 yrs
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations None

Date of operation ... Was autopsy performed? No

What test confirmed diagnosis? Usual

5 Was disease or injury in any way related to occupation of deceased? No
If so, specify ...
(Signed) Thomas S. Fiorentino M.D.
(Address) 76 Main St. Date 6-1-49, 19...

6 Westlawn Cemetery, Lowell, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 3rd, 1949

7 NAME OF FUNERAL DIRECTOR Robert T. Morse
ADDRESS 170 Westford St., Lowell, Mass.

Received and filed June 2, 1949
John J. Rabbeni
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced
HUSBAND of Mary Jane Whitehead
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years 10 Months 9 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Velvet Singer
(Kind of work done during most of working life)

14 Industry or Business: Merrimack Mills

15 Social Security No. None

16 BIRTHPLACE (City) (State or country) Chorley, Lancashire England

PARENTS

17 NAME OF FATHER: William Lowe

18 BIRTHPLACE OF FATHER (City) (State or country): Could not be learned

19 MAIDEN NAME OF MOTHER: Francis Forrest

20 BIRTHPLACE OF MOTHER (City) (State or country): Could not be learned

21 Informant Mrs. Anne A. Atherton
(Address) 10 Marlboro Rd., Southboro, Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone MD
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) June 2, 1949 (Date of Issue of Permit)

100M-(D)-10-48-24858

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 14n

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Robert Francis Cheney
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Latisquama Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 11 days. In place of residence 45 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 3 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from May 22 1949 to June 3 1949

I last saw him alive on June 2 1949 Death is said to have occurred on the date stated above, at 6:10A. m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Probable Cancer of stomach with metastases to lungs — 6mos.

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Coronary heart disease 5yrs.

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis? X-Ray chest

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Hugh Folsom, M. D.

(Address) Framingham, Mass Date 6/3/49 19....

6 Fairmont Cemetery, Lee, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 6, 1949 19....

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Cotting Ave., Marlboro, Mass.

Received and filed July 8 19 49

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced HUSBAND of Emma J. Port
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years 5 Months 16 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Clergyman
(Kind of work done during most of working life)

14 Industry or Business: Clergyman (retired)

15 Social Security No.....

16 BIRTHPLACE (City) Lee, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Robert B.

18 BIRTHPLACE OF FATHER (City) Tyringham, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Maria L. Couch

20 BIRTHPLACE OF MOTHER (City) Mass.
(State or country)

21 Informant Miss Florence Cheney
(Address) Lee, Mass.

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED June 7, 1949 19....

FORM R-301A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 13

1 PLACE OF DEATH: Worcester (County) Southbora (City or Town)
No. Latisquama Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John J. Colleary
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) —

(a) Residence. No. Latisquama St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 50 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: June (Month) 8 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1949 to June 8, 1949
I last saw h~~im~~ alive on June 8, 1949, death is said to have occurred on the date stated above, at 9 a. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	acute dilitation of heart	4 hrs.
ANTECEDENT CAUSES Due To (b)	arteriosclerosis	20 yrs.
Due To (c)	senility	
OTHER SIGNIFICANT CONDITIONS	Hypertrophied prostate	2 yrs.
	secondary anemia	1 yr.

Major findings: Of operations .....
Date of operation ..... Was autopsy performed? No
What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) Josephine L Kable, M. D.
(Address) 42 W. Main St. Date June 9 1949

6 Burial Place of Burial or Cremation: Rural Southboro Mass (City or Town)
DATE OF BURIAL June 10 1949

7 NAME OF FUNERAL DIRECTOR Wm M Tighe
ADDRESS Marlboro Mass

Received and filed June 11 1949
Frances E Raberu (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed or divorced
HUSBAND of Alice McElhattern (Give maiden name of wife in full)
(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Shoeworker (Kind of work done during most of working life)

14 Industry or Business: Shop

15 Social Security No. 032-20-8512

16 BIRTHPLACE (City) (State or country) Ireland

PARENTS

17 NAME OF FATHER William J. Colleary

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Nellie Connelly

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Helen Colleary Daughter
(Address) Latisquama Rd Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)
Agent Board of Health (Official Designation) June 9, 1949 (Date of Issue of Permit)

100M-(D)-10-48-24858

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 16

1 PLACE OF DEATH: Worcester (County) Fayville (City or Town) No. Maple St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna C Braun (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Maple St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 25 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: June (Month) 25 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1940, to June 25, 1949

I last saw her alive on June 24, 1949 death is said to have occurred on the date stated above, at 1.45 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cancer - left breast metastasis	3 yrs
ANTECEDENT CAUSES Due To (b)	Cancer left breast	3 yrs
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations Carcinoma left breast

Date of operation 1945 Was autopsy performed? no

What test confirmed diagnosis? Biopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Roland J VanFan, M. D.

(Address) Westboro Date June 26 1949

6 Rural Place of Burial or Cremation Southboro mass (City or Town)

DATE OF BURIAL June 27 1949

7 NAME OF FUNERAL DIRECTOR William M Tighe

ADDRESS Marlboro mass

Received and filed June 28, 1949

John J. Galeucci (Registrar)

100M-(D)-10-48-24658

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Single

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 59 Years 2 Months 27 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housekeeper (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No.

16 BIRTHPLACE (City) Ballamagarty (State or country) Ireland

PARENTS

17 NAME OF FATHER Michael Braun

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Mary McGinnis

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant Mary F. Farrar (Address) Maple St Fayville mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Jno Ray P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) June 25, 49 (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 17

PLACE OF DEATH
1 Worcester (County)
Southboro (City or Town)
No. Connors Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Juliet (Marshall) Page
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 3 Ellis Ave. St. Marlboro Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 10 months ..... days. In place of residence 38 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July (Month) 21 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 17, 1949, to July 21, 1949
I last saw her alive on July 20, 1949 death is said to have occurred on the date stated above, at 5.10 p.m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Thrombus myocarditis 1 yr

ANTECEDENT CAUSES Due To (b) Arteriosclerosis 20 yrs

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations no operation

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) G. W. Smith, M. D.
(Address) Marlboro Date 7/22 1949

6 Maplewood Marlboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 22, 1949

7 NAME OF FUNERAL DIRECTOR Sumner L. Gage
ADDRESS Marlboro Mass.

Received and filed July 23 1949
John J. Rabbett (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female | 9 COLOR OR RACE White | 10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of True B. Page (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 93 Years 4 Months 5 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. .....

16 BIRTHPLACE (City) North Fairfield (State or country) Maine

PARENTS

17 NAME OF FATHER Marshall

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Maine

19 MAIDEN NAME OF MOTHER Christine Bowman

20 BIRTHPLACE OF MOTHER (City) ..... (State or country) Maine

21 Informant Dwight G. Page
(Address) 3 Ellis Ave. Marlboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)
Agent Board of Health June 22, 1949
(Official Designation) (Date of Issue of Permit)

100M-(C)-10-48-24658

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 18

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town)
No. East Maine St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ida L. Bagley (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. East Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Aug. (Month) 20 (Day) 1949. (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1946, to Aug 20, 1949

I last saw her alive on Aug 19, 1949, death is said to have occurred on the date stated above, at 7 P. m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Metastatic Adenocarcinoma

ANTECEDENT CAUSES Due To (b) Adenocarcinoma of the Colon.

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations Adenocarcinoma of Colon

Date of operation ..... Was autopsy performed? no

What test confirmed diagnosis? .....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) Maurice E. Costin, M. D.
(Address) 190 Concord Street Date Aug 21 1949

6 Burial Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Aug 23 1949

7 NAME OF FUNERAL DIRECTOR John J. Brown
ADDRESS 95 Main St Marlboro

Received and filed August 23 1949

John J. Rabeno (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female | 9 COLOR OR RACE: White | 10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Widow

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Charles J. Bagley
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 64 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. .....

16 BIRTHPLACE (City) Southboro (State or country) Mass.

PARENTS

17 NAME OF FATHER Warren C. Louise

18 BIRTHPLACE OF FATHER (City) Med Medway (State or country) Mass

19 MAIDEN NAME OF MOTHER Carrie Stone

20 BIRTHPLACE OF MOTHER (City) Shrewsbury (State or country) Mass

21 Informant Mrs Paul Redmond
(Address) East Main St Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) August 22 49 (Date of Issue of Permit)

100M-(D)-10-48-24658

18a

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough
(City or town making return)

Registered No. 155

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nellie Higgins
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran if so specify WAR) no

(a) Residence. No. ... St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death Instit. 3 years 7 months 18 days. In place of residence ... years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Sept. 9, 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1947, to Sept. 9, 1949

I last saw her alive on Sept. 9, 1949 death is said to have occurred on the date stated above, at 12:15 p. m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) ...

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Due To (b) Chronic Valvular Disease (Aortic)? unk.

Due To (c) ...

OTHER SIGNIFICANT CONDITIONS ...

Major findings:
Of operations ...

Date of operation ... Was autopsy performed? ...

What test confirmed diagnosis? clinical

5 Was disease or injury in any way related to occupation of deceased? no.
If so, specify ...

(Signed) Nicolas M. Weisz M. D.
(Address) Westborough State Hospital Date 9/9 1949

6 St. Luke's, Westboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Sept. 12, 1949

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westborough, Mass.

Received and filed Oct 1st 1949

John J. Rabere
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: white

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): single

10a If married, widowed, or divorced
HUSBAND of ...
(Give maiden name of wife in full)
(or) WIFE of ...
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years ... Months ... Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: housekeeper
(Kind of work done during most of working life)

14 Industry or Business: ...

15 Social Security No. ...

16 BIRTHPLACE (City) Cothford
(State or country) Ireland

PARENTS

17 NAME OF FATHER Michael Higgins

18 BIRTHPLACE OF FATHER (City) ...
(State or country) Ireland

19 MAIDEN NAME OF MOTHER Catherine Cronin

20 BIRTHPLACE OF MOTHER (City) ...
(State or country) Ireland

21 Informant (Address) Westborough State Hospital records

A TRUE COPY.
ATTEST: Russell A. Dunne
(Registrar of City or Town where death occurred)

DATE FILED Sept. 14 1949

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 19

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Peter Bianchi (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. 59 Pleasant St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 51 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 12, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1944, to Sept. 12, 1949

I last saw him alive on Sept. 12, 1949, death is said to have occurred on the date stated above, at 1 P.M. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) AS Heart disease with congestive failure & uremia	6 mos.
ANTECEDENT CAUSES Due To (b)	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Chronic bronchitis	10 yrs.

Major findings:
Of operations.....
Date of operation..... Was autopsy performed?.....
What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Hugh Folsom, M. D.
(Address) Framingham, Mass. Date 9/13/49 19

6 Rural Cemetery Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL September 15, 1949 19

7 NAME OF FUNERAL DIRECTOR John L. Norton & Son
ADDRESS Framingham, Mass.

Received and filed 19 49
John J. Bakens
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Maria Bina
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Laborer
(Kind of work done during most of working life)

14 Industry or Business: N.H. Railroad (Retired)

15 Social Security No. 019-20-0058

16 BIRTHPLACE (City) Italy
(State or country)

PARENTS

17 NAME OF FATHER Quirico Bianchi

18 BIRTHPLACE OF FATHER (City) Italy
(State or country)

19 MAIDEN NAME OF MOTHER Rose Sommare

20 BIRTHPLACE OF MOTHER (City) Italy
(State or country)

21 Informant Mrs. Maria Bianchi
(Address) Southboro, Mass.

A TRUE COPY
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED September 16, 1949 19

19a

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 169

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Nishan Jafankjian (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cordaville Road (Usual place of abode) ℅ Southborough, Mass. (If nonresident, give city or town and State)

Length of stay: In place of death years 7 months 2 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH September 26, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

cerebral hemorrhage
chr. myocarditis

5 Accident, suicide, or homicide (specify)

Date and hour of injury 19

Where did Injury occur? (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? (Specify type of place)

Manner of Injury (How did injury occur?)

Nature of Injury

While at work? Was autopsy performed? yes

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Walter F. Mahoney, M. D.

(Address) Westboro, Mass. Date 9-28 1949

7 Pine Grove, Westboro, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Oct. 1, 1949

8 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed Oct 4th 1949

John J. Bakens (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	white	single

11a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 55 Years Months Days | If under 24 hours Hours Minutes

14 Usual Occupation: Laborer (Farm) (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No.

17 BIRTHPLACE (City) (State or country) cannot be learned

PARENTS

18 NAME OF FATHER cannot be learned

19 BIRTHPLACE OF FATHER (City) (State or country) cannot be learned

20 MAIDEN NAME OF MOTHER cannot be learned

21 BIRTHPLACE OF MOTHER (City) (State or country) cannot be learned

22 Informant (Address) Westborough State Hospital records

A TRUE COPY.
ATTEST: Ernest A. Dunne (Registrar of City or Town where death occurred)

DATE FILED Oct. 3, 1949

FORM R-301A

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 20

1 PLACE OF DEATH: Worcester (County) — Southborough (City or Town) — No. Oak Hill Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Albert Sewall Woodward (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR) No

(a) Residence. No. Oak Hill Rd. St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 27 years 0 months 0 days. In place of residence 27 years 0 months 0 days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Sept (Month) 29 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1944, to Sept 29, 1949. I last saw h[e] alive on Sept 29, 1949, death is said to have occurred on the date stated above, at 6.45 P m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Apoplexy Cerebral	48 hours
ANTECEDENT CAUSES Due To (b) Arterio sclerosis	-2-
Due To (c)	
OTHER SIGNIFICANT CONDITIONS none	

Major findings: Of operations none

Date of operation none Was autopsy performed?

What test confirmed diagnosis? Physical exam in office

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Roland L Hamilton, M. D.

(Address) Westborough Date Sept 29 1949

6 Lakeview Cemetery Wakefield (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL October 3 1949

7 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS 15-21 Cottage Ave. Marlboro

Received and filed Oct. 4 1949

John J. Rabeni (Registrar)

100M-(D)-10-48-24858

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	white	married

10a If married, widowed, or divorced HUSBAND of Alice Rae married (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years -0- Months 29 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired High School Principal (Kind of work done during most of working life)

14 Industry or Business: Public school

15 Social Security No. - none -

16 BIRTHPLACE (City) Francestown (State or country) New Hampshire

PARENTS

17 NAME OF FATHER Abner Burnham Woodward

18 BIRTHPLACE OF FATHER (City) Lyndeborough (State or country) New Hampshire

19 MAIDEN NAME OF MOTHER Caroline Perkins

20 BIRTHPLACE OF MOTHER (City) Lynn (State or country) New Hampshire

21 Informant Alice L. Woodward wife (Address) Fayville Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) Sept 30, 1949 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough
(City or town making return)

Registered No. 185 21

1 PLACE OF DEATH
Middlesex (County)
Marlborough (City or Town)
No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Harry F. Hurd
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Framingham Road St. Southboro, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Oct 19, 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1949, to Oct 19, 1949

I last saw him alive on Oct 18, 1949, Death is said to have occurred on the date stated above, at 6.45 A m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cerebral thrombosis	1 wk
ANTECEDENT CAUSES Due To (b)	Gen Art. sclerosis	10 Yr
Due To (c)		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....

(Signed) R. A. Johnson, M. D.
(Address) Marlboro, Mass Date 10-19 1949

6 Woodland Cambridge, N. Y.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL October 21, 1949

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlborough

Received and filed Oct 20, 1949
John J Raleen
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
M	W	Married

10a If married, widowed, or divorced
HUSBAND of Maude DeWitt
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 80 Years 6 Months 11 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: Retired farmer
(Kind of work done during most of working life)

14 Industry or Business: Dairy & Gen. Farm

15 Social Security No.....

16 BIRTHPLACE (City) Sandgate, Vt
(State or country)

PARENTS

17 NAME OF FATHER Levi Hurd

18 BIRTHPLACE OF FATHER (City) Sandgate Vt.
(State or country)

19 MAIDEN NAME OF MOTHER Orlena Sheldon

20 BIRTHPLACE OF MOTHER (City) Manchester, Vt
(State or country)

21 Informant Mrs. Maude Hurd
(Address) Southboro

A TRUE COPY.
ATTEST: F. J. Bertrand
(Registrar of City or Town where death occurred)

DATE FILED Oct 20, 1949

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough
(City or town making return)

Registered No. 194 22

1 PLACE OF DEATH

Middlesex
(County)

Marlborough
(City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lucretia E. Tebo
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. East Main St St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH October 30, 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 16, 1949 to Oct 29, 1949

I last saw her alive on Oct 29, 1949 Death is said to have occurred on the date stated above, at 5.30 A. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Bronchopneumonia	3 wks
ANTECEDENT CAUSES Due To (b) Chr myocarditis	1 yr
Due To (c) Arteriosclerosis	10 yr
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) David D. Sher, M. D.

(Address) Marlborough Date 10-31-49

6 Maplewood Marlborough
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 1, 1949 19

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Marlborough

Received and filed Nov 3, 1949 19

John J. Rabbett
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Joseph Tebo
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 10 Months 2 Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation: housewife
(Kind of work done during most of working life)

14 Industry or Business: at home

15 Social Security No.....

16 BIRTHPLACE (City) Nova Scotia
(State or country)

PARENTS

17 NAME OF FATHER John McLean

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Chrisander Crouse

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Joseph W.L. Tebo
(Address) Lakeport, N.H.

A TRUE COPY.
ATTEST: F. J. Butterfield
(Registrar of City or Town where death occurred)
Nov 3, 1949

DATE FILED .....19.....

FORM R-301

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 23

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town)

No. Melendy Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edgar F. Chick (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Ward Rd St. (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 2 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov (Month) 3 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1949, to Nov 3, 1949

I last saw h... alive on Nov 2, 1949 death is said to have occurred on the date stated above, at 5:30 a. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Sclerotic Heart Disease	1 mo
ANTECEDENT CAUSES Due To (b) Arterio sclerosis	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations none

Date of operation ..... Was autopsy performed? .....

What test confirmed diagnosis? examination

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) C. W. Smyth, M. D.

(Address) Marlboro Date 11/3, 1949

6 Maplewood Marlboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov 5, 1949

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS Marlboro, Mass.

Received and filed Nov 7, 1949

John J. Rabeni (Registrar)

100M-(C)-10-48-24858

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)
(or) WIFE of Minnie E. Carter (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 11 Months 11 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Retired shoeworker (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. .....

16 BIRTHPLACE (City) Marlboro (State or country) Mass.

PARENTS

17 NAME OF FATHER Daniel Chick

18 BIRTHPLACE OF FATHER (City) ..... (State or country) Maine

19 MAIDEN NAME OF MOTHER Sarah Garfield

20 BIRTHPLACE OF MOTHER (City) Not obtainable (State or country)

21 Informant Mrs Harry N. Gillin (Address) Lynnfield Mass.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) 11-4-49 (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

Registered No. 24

1 PLACE OF DEATH: Worcester (County) — (City or town making return)
Southboro (City or Town)
No. Ward Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Emily Little Miner (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Ward Road Southboro St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 12 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov (Month) 4 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1949, to Nov 4, 1949
I last saw h-s alive on Nov 3, 1949 death is said to have occurred on the date stated above, at ..... m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma of Breast	year
ANTECEDENT CAUSES Due To (b) metastases of the brain	2 mo
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations no operation
Date of operation ..... Was autopsy performed? .....
What test confirmed diagnosis? Pathological

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify .....
(Signed) E. W. Donnelly, M. D.
(Address) Southboro Date 11/4 1949

6 Forest Hills Cemetery Boston
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Nov 7, 1949

7 NAME OF FUNERAL DIRECTOR Guyon L. Gage
ADDRESS 15 Cotting Ave., Marlboro

Received and filed Nov 7 1949
John J. Rabeno (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female | 9 COLOR OR RACE White | 10 SINGLE MARRIED WIDOWED or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of Arthur P. Miner
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 66 Years 10 Months 10 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. .....

16 BIRTHPLACE (City) Tyrrell (State or country) Mass.

PARENTS

17 NAME OF FATHER James Little

18 BIRTHPLACE OF FATHER (City) England (State or country)

19 MAIDEN NAME OF MOTHER

20 BIRTHPLACE OF MOTHER (City) England (State or country)

21 Informant Arthur P. Miner
(Address) Ward Rd., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Linwood P. Stone
(Signature of Agent of Board of Health or other)
Agent, Board of Health (Official Designation) 11-4-49 (Date of Issue of Permit)

100M-(C)-10-48-24858

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 24a

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John Arthur Williams
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Highland Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 6 days. In place of residence 6 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 18, 1949
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from 10/20/, 19 48 to 11/18/49, 19 .....

I last saw h im alive on 11/17/49, 19 ....., death is said to have occurred on the date stated above, at 2:00AM m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Leukemia	13mos
ANTECEDENT CAUSES (b) Due To	
(c) Due To	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations none

Date of operation none Was autopsy performed? yes

What test confirmed diagnosis? Blood Studies

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify

(Signed) Bruce R. Brown M.D.
(Address) Framingham, Mass. Date 11/18/ 19 49

6 Dell Park Cemetery, Natick, Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 21, 1949 19 .....

7 NAME OF FUNERAL DIRECTOR Frederick A. Gibbs

ADDRESS Cochituate, Mass.

Received and filed Dec. 10 19 49

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Single

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)

(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 10 Years 4 Months 5 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Student
(Kind of work done during most of working life)

14 Industry or Business: Public School

15 Social Security No. none

16 BIRTHPLACE (City) Natick, Mass.
(State or country)

PARENTS

17 NAME OF FATHER John Albert Williams

18 BIRTHPLACE OF FATHER (City) Framingham, Mass.
(State or country)

19 MAIDEN NAME OF MOTHER Mirdza Kalnceen

20 BIRTHPLACE OF MOTHER (City) Framingham, Mass.
(State or country)

21 Informant John A. Williams
(Address) Highland Rd., Southville, Mass.

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED November 22, 1949

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 241

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Josephine Cecelia Woodard (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 3 days. In place of residence 5 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 20, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1949 to Nov. 20, 1949

I last saw her alive on Nov. 20, 1949, death is said to have occurred on the date stated above, at 2:45PM m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Cardiac Tamponade	2d
ANTECEDENT CAUSES Due To (b)	Ruptured Myocardium	2d.
Due To (c)	Coronary Thrombosis acute posterior arteriosclerosis 5yrs	6days
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations .....

Date of operation ..... Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Timothy P. Stone

(Address) Southboro, Mass. Date 11/20/ 1949

6 Mt. Pleasant Cem., Arlington, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 23, 1949

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS 62W. Main St., Westboro, Mass.

Received and filed Dec. 12 1949

John J. Rabeni (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of George H. Woodard (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 9 Months 27 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. .....

16 BIRTHPLACE (City) Lynn, Mass. (State or country)

PARENTS

17 NAME OF FATHER Cannot learn Finnon

18 BIRTHPLACE OF FATHER (City) Lynn, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Ellen Noonan

20 BIRTHPLACE OF MOTHER (City) Lynn, Mass. (State or country)

21 Informant Mrs. Eleanor Rosso (Address) Southville Rd., Southville

A TRUE COPY

ATTEST: Wm. J. Walsh (Registrar of City or Town where death occurred)

DATE FILED Nov. 22, 1949

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 24e

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Community Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Evelyn Baker (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Latisquama Avenue St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 9 days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 22, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1949 to Nov. 22, 1949

I last saw her alive on Nov. 21, 1949, death is said to have occurred on the date stated above, at 11:10Am m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Chronic myocarditis

c Arteriosclerotic charges.

ANTECEDENT CAUSES Due To (b) Coronary thrombosis

Left Ventricular Failure

Due To (c)

OTHER SIGNIFICANT CONDITIONS Diabetes Mellitus

INTERVAL BETWEEN ONSET AND DEATH

Major findings: Of operations.....

Date of operation..... Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....

If so, specify.....

(Signed) Joseph Annunziata M. D.

(Address) Hopkinton, Mass. Date 11/23/ 1949

6 Pine Grove Cemetery, Westboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 25, 1949

7 NAME OF FUNERAL DIRECTOR Irving W. Harper

ADDRESS Westboro, Mass.

Received and filed Dec. 10 1949

John J. Bakeun
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Fred Baker
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 65 Years 9 Months 15 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No. None

16 BIRTHPLACE (City) Westborough, Mass. (State or country)

PARENTS

17 NAME OF FATHER George Macker

18 BIRTHPLACE OF FATHER (City) Grafton, Mass. (State or country)

19 MAIDEN NAME OF MOTHER Elizabeth Allen

20 BIRTHPLACE OF MOTHER (City) Grafton, Mass. (State or country)

21 Informant George Lindsay
(Address) Southboro, Mass.

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED November 23, 1949

FORM R-301

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 26

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town) No. Fisher Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Hannah M O'Connell (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Fisher Rd St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. (Month) 28 (Day) 1949 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 2, 1947, to Nov. 28, 1949. I last saw her alive on Nov. 28, 1949, death is said to have occurred on the date stated above, at 10 55 P m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma of Lungs	6 Mos.
ANTECEDENT CAUSES Due To (b) Malignant Tumor of Glands of Neck	1 yr.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations: —

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Leonard E. Thurston M. D.

(Address) Marlboro, Mass. Date 11/29/49

6 Immaculate Conception Marlboro (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL Dec 2. 1949

7 NAME OF FUNERAL DIRECTOR Wm M. Tighe

ADDRESS Marlboro Mass

Received and filed Dec. 1 1949

John J. Rabeni (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female

9 COLOR OR RACE White

10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word) Single

10a If married, widowed, or divorced
HUSBAND of..... (Give maiden name of wife in full)
(or) WIFE of..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 63 Years.....Months.....Days. If under 24 hours .....Hours.....Minutes

13 Usual Occupation (Kind of work done during most of working life) Claim adjuster clothing

14 Industry or Business: M. T. A.

15 Social Security No. 011-09-9178

16 BIRTHPLACE (City) (State or country) Southboro

PARENTS

17 NAME OF FATHER David O'Connell

18 BIRTHPLACE OF FATHER (City) (State or country) Ireland

19 MAIDEN NAME OF MOTHER Hannah Toomey

20 BIRTHPLACE OF MOTHER (City) (State or country) Ireland

21 Informant (Address) Margaret O'Connell Fisher Rd Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) Nov 30 1949 (Date of Issue of Permit)

100M-(C)-10-48-24858

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 34

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice Holbrook Bruce (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parkerville Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 6hrs. years months 1/4 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 5, 1949 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Aspiration of vomitus
with asphyxiation
Sudden death

5 Accident, suicide, or homicide (specify) accident

Date and hour of injury 12/5/49 10PM 19

Where did Injury occur? Framingham, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Framingham Union Hospital (Specify type of place)

Manner of Injury Inhaled vomitus (How did injury occur?)

Nature of Injury Asphyxiation

While at work? no Was autopsy performed? view

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Michael F. Burke, MD, M. D.

(Address) Natick, Mass. Date 12/6/ 19 49

7 Edgell Grove Cem., Framingham, Mass. Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL December 8, 1949 19

8 NAME OF FUNERAL DIRECTOR Frederick A. Cookson

ADDRESS Framingham, Mass.

Received and filed Jan. 10 19 49

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

11a If married, widowed, or divorced
HUSBAND of (Give maiden name of wife in full)
(or) WIFE of James Drummond Bruce (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 79 Years 7 Months 1 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: At Home (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No.

17 BIRTHPLACE (City) (State or country) Dover, New Hampshire

PARENTS

18 NAME OF FATHER James Holbrook

19 BIRTHPLACE OF FATHER (City) Cannot learn (State or country) Mass.

20 MAIDEN NAME OF MOTHER Frances Cross

21 BIRTHPLACE OF MOTHER (City) Brooklyn, (State or country) New York

22 Informant Ethel A. Bodge
(Address) 113 Grove St., Auburndale

A TRUE COPY.
ATTEST: Wm. L. Walsh
(Registrar of City or Town where death occurred)

DATE FILED December 7, 1949

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 1

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ernest Gazzola (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Sears Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 49 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH January 11, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Coronary occlusion
Fracture of 11th. dorsal vertebra
Sudden death

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 12/21/49 (date uncertain) 19

Where did Injury occur? Southboro, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Home (Specify type of place)

Manner of Injury Slipped on rug & fell (How did injury occur?)

Nature of Injury Compression fracture of vertebra

While at work? no Was autopsy performed? view

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Michael F. Burke, M. D.

(Address) Natick, Mass. Date 1/12/50

7 Rural Southboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL January 21, 1950 19

8 NAME OF FUNERAL DIRECTOR William M. Tighe

ADDRESS 3 Windsor St., Marlboro

Received and filed Feb. 10 1950

John J. Bakeman
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of (old) (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 74 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Kitchen helper (Kind of work done during most of working life)

15 Industry or Business: Framingham Union Hosp. Wellesley College

16 Social Security No. 019-20-6288

17 BIRTHPLACE (City) (State or country) Italy

PARENT

18 NAME OF FATHER Carlo Gazzola

19 BIRTHPLACE OF FATHER (City) (State or country) Italy

20 MAIDEN NAME OF MOTHER Maria Biazzini

21 BIRTHPLACE OF MOTHER (City) (State or country) Italy

22 Informant Mary F. Carr
(Address) Sears Rd., Southboro

A TRUE COPY.
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED January 13, 1950 19

FORM R-301

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 2

1 PLACE OF DEATH: Middlesex (County) Southboro (City or Town)

No. East Main St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Wallace Mortimer Drye (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. East Main St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 39 years....months....days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Jan (Month) 30 (Day) 1950 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1949 to Jan 30, 1950

I last saw h... alive on Jan 30, 1950, death is said to have occurred on the date stated above, at 3:30 A.m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Myocardial degeneration	7yrs
ANTECEDENT CAUSES Due To (b) Arteriosclerosis	?
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations ....

Date of operation .... Was autopsy performed? ....

What test confirmed diagnosis? Physical examination

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify ....

(Signed) Roland C Vaughan, M. D.

(Address) Westboro Mass Date 1/30 1950

6 Rural Place of Burial or Cremation Southboro (City or Town)

DATE OF BURIAL February 1, 1950

7 NAME OF FUNERAL DIRECTOR Gunnerdale Gage

ADDRESS 15-21 Cottage Ave., Marlboro

Received and filed February 1 1950

John J Rabeni (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Widowed

10a If married, widowed, or divorced HUSBAND of Hannah Chamberlain (Give maiden name of wife in full)

(or) WIFE of .... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 85 Years 6 Months 18 Days | If under 24 hours .... Hours .... Minutes

13 Usual Occupation: Painter and paperhanger (Kind of work done during most of working life)

14 Industry or Business: House decorating

15 Social Security No. None

16 BIRTHPLACE (City) Baxville (State or country) New Brunswick

PARENTS

17 NAME OF FATHER William Drye

18 BIRTHPLACE OF FATHER (City) Canada (State or country)

19 MAIDEN NAME OF MOTHER Arabelle Ingels

20 BIRTHPLACE OF MOTHER (City) Canada (State or country)

21 Informant Mrs Raymond Olsen (Address) East Main St., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) Jan 31, 1950 (Date of Issue of Permit)

100M-(C)-10-46-24658

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

3

MARLBOROUGH (City or town making return)

Registered No. 39

PLACE OF DEATH
1 MIDDLESEX (County)
MARLBOROUGH (City or Town)
No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Agnes Baker (Dolan)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Middle[illegible] Road St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 14 years months days. In place of residence 50 years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Feb 28, 1950
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1950, to Feb 28, 1950, 19..., I last saw her alive on Feb 28, 1950, death is said to have occurred on the date stated above, at 6.30 P.M.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinonatosis	2 mo.
ANTECEDENT CAUSES Due To (b) Carcinoma of colon	4 mos
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations None

Date of operation ... Was autopsy performed? no

What test confirmed diagnosis? X-ray

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) William D. Roche, M. D.
(Address) Marlborough Date 3-1-50, 19...

6 Rural Southboro, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL March 3, 1950, 19...

7 NAME OF FUNERAL DIRECTOR Wm. M. Tighe
ADDRESS Marlborough, Mass

Received and filed ... 19...
John D. Ryan
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
F	W	Widowed

10a If married, widowed, or divorced
HUSBAND of ... (Give maiden name of wife in full)
(or) WIFE of Fred Baker (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years Months Days | If under 24 hours Hours Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business:

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Manchester, England

PARENTS

17 NAME OF FATHER Cannot be learned

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Cannot be learned

20 BIRTHPLACE OF MOTHER (City) (State or country) England

21 Informant Henry Baker
(Address) Southboro, Mass

A TRUE COPY.
ATTEST: F. J. Bertrand
(Clerk or Registrar of City or Town where death occurred)

DATE FILED ... 19...

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 4

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ella C. Eaton (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Flagg Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 14 days. In place of residence 36 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 14, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1950, to March 14, 1950

I last saw her alive on March 13, 1950, death is said to have occurred on the date stated above, at 2:30AM m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Acute myocardial infarction	16days
ANTECEDENT CAUSES Due To (b) Hypertension & Coronary sclerosis	
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Old Cerebral thrombosis	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? Electrocardiogram

5 Was disease or injury in any way related to occupation of deceased? no If so, specify.....

(Signed) Herbert M. Levenson, M. D.

(Address) Framingham, Mass. Date 3/14/1950

6 North Burial Ground Providence, RI (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL March 16, 1950

7 NAME OF FUNERAL DIRECTOR Summer C. Gage

ADDRESS Marlboro, Mass.

Received and filed April 8, 1950

John J. Rabesi (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full)

(or) WIFE of Harris D. Eaton (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 1 Months 8 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No.....

16 BIRTHPLACE (City) Providence, RI (State or country)

PARENTS

17 NAME OF FATHER Crawford Allen

18 BIRTHPLACE OF FATHER (City) Providence, RI (State or country)

19 MAIDEN NAME OF MOTHER Clara Dennison Foster

20 BIRTHPLACE OF MOTHER (City) Providence, R.I. (State or country)

21 Informant Harris D. Eaton (Address) Flagg Rd., Southboro, Mass.

A TRUE COPY ATTEST: Wm. J. Walsh (Registrar of City or Town where death occurred)

DATE FILED March 16, 1950

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 5

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary E. Eagan
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Road St. Fayville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 15 years 6 months ....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 20, 1950
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March 21 19 48 to March 20, 19 50

I last saw her alive on March 20, 19 50 death is said to have occurred on the date stated above, at 5:30PM m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Arteriosclerotic heart Disease	2wks.
ANTECEDENT CAUSES Due To (b) Arteriosclerosis	2yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation.....Was autopsy performed? no

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....

(Signed) Timothy P. Stone M. D.
(Address) Southboro, Mass. Date 3/22/50 19

6 St. Stephen's Framingham, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 23, 1950 19

7 NAME OF FUNERAL DIRECTOR Eugene McCarthy

ADDRESS Framingham, Mass.

Received and filed April 2 19 50

John J. Rabbitt
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Single

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of.....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 75 Years 9 Months ....Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housework
(Kind of work done during most of working life)

14 Industry or Business: At Home

15 Social Security No.....

16 BIRTHPLACE (City) Framingham, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Owen Eagan

18 BIRTHPLACE OF FATHER (City) New York
(State or country)

19 MAIDEN NAME OF MOTHER Ellen Hefferman

20 BIRTHPLACE OF MOTHER (City) Ireland
(State or country)

21 Informant Mr. Earl Smiddy
(Address) Fayville, Mass.

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED March 22, 1950 19

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Westborough (City or town making return)

Registered No. 61 6

1 PLACE OF DEATH: Worcester (County); Westborough (City or Town)

No. Westborough State Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Gerald E. Jolly (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death years 2 months 21 days. In place of residence years months days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH March 23, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1950, to Mar. 23, 1950

I last saw him alive on Mar. 23, 1950, death is said to have occurred on the date stated above, at 8:05 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Tuberculous Peritonitis	6 mos
ANTECEDENT CAUSES (b) Due To	Tuberculous Hepatitis	6 mos
(c) Due To		
OTHER SIGNIFICANT CONDITIONS		

Major findings: Of operations.....

Date of operation..... Was autopsy performed? yes

What test confirmed diagnosis? Post Mortem

5 Was disease or injury in any way related to occupation of deceased?..... If so, specify.....

(Signed) Donald E.A. Montgomery, M. D.

(Address) Westboro, Mass. Date 3/24/ 1950

6 Rural Cemetery, Southboro Place of Burial or Cremation (City or Town)

DATE OF BURIAL March 26, 1950

7 NAME OF FUNERAL DIRECTOR William M. Tighe

ADDRESS 3 Windsor St., Marlboro

Received and filed April 29 1950

John T. Galen (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	white	married

10a If married, widowed, or divorced HUSBAND of Marion Fay (Give maiden name of wife in full)

(or) WIFE of..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 45 Years 8 Months 19 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Chef (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) (State or country) Nova Scotia

PARENTS

17 NAME OF FATHER Frank Jolly

18 BIRTHPLACE OF FATHER (City) (State or country) England

19 MAIDEN NAME OF MOTHER Ida Banks

20 BIRTHPLACE OF MOTHER (City) (State or country) Nova Scotia

21 Informant Westborough State (Address) Hospital records

A TRUE COPY. Attest: Bernice A. Dunne (Registrar of City or Town where death occurred)

DATE FILED March 27 1950

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 7

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Alice Sawin (Ingalls)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Oak Hill Road St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months 8 days. In place of residence 55 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH April 4, 1950
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb. 11 19 49 to April 4, 19 50

I last saw her alive on April 3, 19 50, death is said to have occurred on the date stated above, at 6:30 A.M.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary thrombosis	9 days
ANTECEDENT CAUSES Due To (b) Arteriosclerosis	10 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations none

Date of operation ....Was autopsy performed? no

What test confirmed diagnosis? E.C.G.

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify....

(Signed) Timothy P. Stone, M. D.

(Address) Southboro, Mass. Date 4/4/50

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL April 6, 1950

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS 15 Cotting Ave., Marlboro

Received and filed May 9 1950

John J. Rabeau
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of ....
(Give maiden name of wife in full)
(or) WIFE of Harry W. Sawin
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 78 Years 5 Months 13 Days | If under 24 hours ....Hours ....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: ....

15 Social Security No. ....

16 BIRTHPLACE (City) Brookline, Mass.
(State or country)

PARENTS

17 NAME OF FATHER Charles E. Ingalls

18 BIRTHPLACE OF FATHER (City) New Hampshire
(State or country)

19 MAIDEN NAME OF MOTHER Susan R. Blood

20 BIRTHPLACE OF MOTHER (City) Concord, N.H.
(State or country)

21 Informant Miss Ethel Sawin
(Address) Oak Hill Road, Southboro

A TRUE COPY.
ATTEST: Edw. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED April 6, 1950

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

MARLBOROUGH (City or town making return)

Registered No. 81 79

1 PLACE OF DEATH: MIDDLESEX (County); MARLBOROUGH (City or Town)

No. Marlboro Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Violet M. Hunt (Cook)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. East Main St St. Southboro, Mass
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 7 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 6, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from June, 1942, to May 6, 1950, 19....
I last saw her alive on May 6, 50, death is said to have occurred on the date stated above, at 10.28 A.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Cerebral hemorrhage	6 dys
ANTECEDENT CAUSES Due To (b) Hypertension	10 Yr
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed?.....
What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased?.....
If so, specify.....
(Signed) David D. Sher, M. D.
(Address) Marlboro Date May 6, 50

Rural Southboro, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL May 9, 1950 19....

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Marlborough, Mass

Received and filed May 9, 1950 19....
John F. Baker
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
F	W	Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Leonard Hunt
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 67 Years 6 Months 22 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: home

15 Social Security No.....

16 BIRTHPLACE (City) Halifax, N.S.
(State or country)

PARENTS

17 NAME OF FATHER Howard E. Cooke

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER Annie Miller

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Leonard Hunt
(Address) Southboro

A TRUE COPY.
ATTEST: F. J. Bertrand
(Registrar of City or Town where death occurred)
DATE FILED May 8, 1950

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Marlborough
(City or town making return)

Registered No. 95 7B

1 PLACE OF DEATH: Middlesex (County) — Marlboro (City or Town) — No. Marlborough Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Andrew Fales Bigelow
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Fisher Rd. St. Southboro
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 1 years 7 days. In place of residence 40 years

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 16, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from April 10, 1950, to May 16, 1950

I last saw him alive on May 16, 1950, death is said to have occurred on the date stated above, at 10:50a m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Pneumonia bilateral diffuse	28 days
ANTECEDENT CAUSES Due To (b) Minal thrombosis of heart with multiple emboli to brain and kidney	4 or 5 days
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Uremic pyelitus chronic bronchectosis	

Major findings: Of operations

Date of operation Was autopsy performed? yes

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. T. Hood M. D.

(Address) Hudson Date 5-16, 1950

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL May 18, 1950

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS 15 Cotting Ave., Marlboro, Mass.

Received and filed May 19, 1950

Francis J. Bertrand
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	white	married

10a If married, widowed, or divorced
HUSBAND of Edith Alice Treble
(Give maiden name of wife in full)

(or) WIFE of
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 56 Years 10 Months 11 Days | If under 24 hours Hours Minutes

13 Usual Occupation: farmer
(Kind of work done during most of working life)

14 Industry or Business: dairy

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Petersham, Mass.

PARENTS

17 NAME OF FATHER Daniel Bigelow

18 BIRTHPLACE OF FATHER (City) (State or country) Wisconsin

19 MAIDEN NAME OF MOTHER Julia Brown

20 BIRTHPLACE OF MOTHER (City) Petersham (State or country) Mass.

21 Informant Edith A. Bigelow
(Address) Fisher Rd., Southboro

A TRUE COPY
ATTEST: F. J. Bertrand
(Registrar of City or Town where death occurred)

DATE FILED July 25, 1950

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 8

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Corner of Temple & Pleasant Sts. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Stuart Baker (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) WW II

(a) Residence. No. Corner of Newton & Cross Sts. St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 21 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH May 30, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Fracture of skull
Multiple fractures

5 Accident, suicide, or homicide (specify) Accident

Date and hour of injury 5/30/50 8:30 P.M. 19

Where did Injury occur? Framingham, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Public Highway (Specify type of place)

Manner of Injury Automobile collision (How did injury occur?)

Nature of Injury Fr. skull & multiple injuries

While at work? no Was autopsy performed? view

6 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Michael F. Burke, M.D., M. D.

(Address) Natick, Mass. Date 5/31/50 19

7 Rural Southboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL June 2, 1950 19

8 NAME OF FUNERAL DIRECTOR Sumner C. Gage

ADDRESS 15 Cotting Ave., Southboro

Received and filed June 2 19 50

Frances A Roberts
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Single

11a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 22 Years 10 Months 1 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Auto mechanic (Kind of work done during most of working life)

15 Industry or Business: Automobile

16 Social Security No. 021-22-3594

17 BIRTHPLACE (City) (State or country) Framingham, Mass.

PARENTS

18 NAME OF FATHER Clarence Edward Baker

19 BIRTHPLACE OF FATHER (City) (State or country) Everett, Mass.

20 MAIDEN NAME OF MOTHER Mary Alderson

21 BIRTHPLACE OF MOTHER (City) (State or country) Middletown, Conn.

22 Informant Clarence E. Baker
(Address) Southboro, Mass.

A TRUE COPY.
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED June 2, 1950 19

FORM R-301

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return) .....

Registered No. 9

1 PLACE OF DEATH: WORCESTER (County); SOUTHBOROUGH (City or Town)

No. SCHOOL St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME GEDEON A. GOULET (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. 169 BROAD St. MARLBORO MASS (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death .....years .....months 5 days. In place of residence 60 years .....months .....days.

*INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 6 (Day) 1950 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1946, to June 6, 1950

I last saw him alive on June 6, 1950, death is said to have occurred on the date stated above, at 9.50 P m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral Embolus	8 Hrs
ANTECEDENT CAUSES Due To (b) Auriculor Fibrillation	3 wks
Due To (c) Arteriosclerotic Heart Disease	5 yrs
OTHER SIGNIFICANT CONDITIONS Lymphosarcoma Left Arm	5 yrs

Major findings: Of operations Lymphosarcoma (Lymphosarcoma) 1949

Date of operation ..... Was autopsy performed? No

What test confirmed diagnosis? Usual

5 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Hanmore & Farrington M.D.

(Address) 781 Main St Marlboro Date 6-9-50 19

6 St Mary's Cemetery Marlboro Mass
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 9 1950

7 NAME OF FUNERAL DIRECTOR DESSEIN & LEDOUX

ADDRESS 451 Lincoln St Marlboro Mass

Received and filed June 9 1950

John J Rabeno (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE / MARRIED / WIDOWED / or DIVORCED (write the word)
MALE	WHITE	WIDOWED

10a If married, widowed or divorced HUSBAND of JEANNE DAIGNEAULT (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years .....Months .....Days | If under 24 hours .....Hours .....Minutes

13 Usual Occupation: LABORER RETIRED (Kind of work done during most of working life)

14 Industry or Business: ICE

15 Social Security No. NONE

16 BIRTHPLACE (City) (State or country) PERTH ONTARIO

PARENTS

17 NAME OF FATHER LOUIS GOULET

18 BIRTHPLACE OF FATHER (City) OTTAWA (State or country) ONT. Canada

19 MAIDEN NAME OF MOTHER MARIE BERTHIAUME

20 BIRTHPLACE OF MOTHER (City) OTTAWA (State or country) ONTARIO

21 Informant Mrs Francis Gormay (Address) 169 Broad St Marlboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) June 7, 1950 (Date of Issue of Permit)

100M-(C)-10-48-24858

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 10

1 PLACE OF DEATH: (County) ..... (City or Town) Southboro

No. Parkerville Rd. St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mrs. Kristina Flanders
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT
(Was deceased a U. S. War Veteran, if so specify WAR) .....

(a) Residence. No. Parkerville Road St. .....
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 50 years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June (Month) 8 (Day) 1950 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1948, to June 8, 1950

I last saw her alive on June 7, 1950, death is said to have occurred on the date stated above, at ..... m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Bronchopneumonia	2 days
ANTECEDENT CAUSES Due To (b)	Pulmonary Fibrosis	1 yr
	Coronary Thrombosis	2 yrs
Due To (c)	Arteriosclerosis	5 yrs
OTHER SIGNIFICANT CONDITIONS	none	

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

Major findings: Of operations none

Date of operation none Was autopsy performed? no

What test confirmed diagnosis? ECG

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify .....

(Signed) Timothy P. Stone M. D.

(Address) Main St., Southboro Date 6-9 1950

6 Rural Cemet. Southboro, Mass.
Place of Burial or Cremation (City or Town)

DATE OF BURIAL June 11 1950

7 NAME OF FUNERAL DIRECTOR John L. Norton & Son

ADDRESS 383 Union Ave. Framingham, Mass.

Received and filed June 13 1950

John J. Rabeni (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
White	Female	Married

10a If married, widowed, or divorced
HUSBAND of .....
(Give maiden name of wife in full)
(or) WIFE of John A. Flanders
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 81 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. .....

16 BIRTHPLACE (City) Bladinge, (State or country) Sweden

PARENTS

17 NAME OF FATHER Sven Johan Johanneson

18 BIRTHPLACE OF FATHER (City) Bladinge, (State or country) Sweden

19 MAIDEN NAME OF MOTHER Katrina Peters Dotter

20 BIRTHPLACE OF MOTHER (City) Toras, (State or country) Sweden.

21 Informant John A. Flanders (husband)
(Address) Parkerville Rd. Southboro.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone
(Signature of Agent of Board of Health or other)

Agent Bd of Health (Official Designation) June 9, 1950 (Date of Issue of Permit)

50M (B)-12-49-900722

FORM R-301A

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 11

1 PLACE OF DEATH: Worcester (County) — Fayville (City or Town) — No. Pleasant St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME: Clementina Baselli (Casinelli) (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Pleasant St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: June (Month) 18 (Day) 1950 (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1949, to June 18, 1950

I last saw her alive on June 17, 1950, death is said to have occurred on the date stated above, at 4.00 p.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Coronary Thrombosis	2 days
ANTECEDENT CAUSES Due To (b)	Arteriosclerosis, generalized	6 months
Due To (c)		5 years
OTHER SIGNIFICANT CONDITIONS	Emphysema, pulmonary	5 years.

Major findings: Of operations: none

Date of operation: — Was autopsy performed? no

What test confirmed diagnosis? none.

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Timothy P. Stone, M. D.

(Address) Southboro, Mass Date 6/20 1950

6 Rural Cemetery, Southboro (Place of Burial or Cremation) (City or Town)

DATE OF BURIAL June 21 1950

7 NAME OF FUNERAL DIRECTOR John Paul Powe

ADDRESS 17 Main St., Marlboro

Received and filed June 23 1950

Frances E Roberts (Registrar)

asst clerk

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED, or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of Paul Baselli (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 77 Years ..... Months ..... Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No. —

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Jacinto Casinelli

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER Unobtainable

20 BIRTHPLACE OF MOTHER (City) (State or country) Unobtainable

21 Informant (Address) Paul Baselli, Pleasant St., Fayville.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent Board of Health (Official Designation) 6/20/50 (Date of Issue of Permit)

100M-(D)-10-48-24658

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham
(City or town making return)

Registered No. 117

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Rest Home St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Anna L. Wyckstrom
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road St. Cordaville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ....years....months....days. In place of residence 43 years....months....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH June 22, 1950
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1947, to June 22, 1950

I last saw her alive on June 22, 1950, death is said to have occurred on the date stated above, at 11 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral embolism	6 wks.
ANTECEDENT CAUSES Due To (b) Auricular fibrillation	5 yrs.
Due To (c) Arteriosclerotic heart disease	5 yrs.
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations....
Date of operation....Was autopsy performed? no
What test confirmed diagnosis?....

5 Was disease or injury in any way related to occupation of deceased?....
If so, specify....
(Signed) Timothy P. Stone M. D.
(Address) Main St., Southboro 6/23, 1950

6 Rural Southboro, Mass.
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 25, 1950

7 NAME OF FUNERAL DIRECTOR Frederick A. Cookson
ADDRESS Framingham, Mass.

Received and filed July 19, 1950
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widow

10a If married, widowed, or divorced
HUSBAND of....
(Give maiden name of wife in full)
(or) WIFE of Alfred Wyckstrom
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 5 Months 28 Days | If under 24 hours ....Hours....Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:....

15 Social Security No....

16 BIRTHPLACE (City)....Stockholm, Sweden
(State or country)

PARENTS

17 NAME OF FATHER Lars Jacobson Malmquist

18 BIRTHPLACE OF FATHER (City)....Sweden
(State or country)

19 MAIDEN NAME OF MOTHER Helena Dorothea Larsdotter

20 BIRTHPLACE OF MOTHER (City)....Sweden
(State or country)

21 Informant Carl F. Wyckstrom
(Address) Southville Rd., Cordaville

A TRUE COPY.
ATTEST: ....
(Registrar of City or Town where death occurred)

DATE FILED June 26, 1950

FORM R-301

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 12

1 PLACE OF DEATH: Worcester (County) Southboro (City or Town)

No. Marlboro Rd St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Julia I Fitzgerald (nee O'Connell)
(If deceased is a married, widowed or divorced woman, give also maiden name.)

(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Marlboro Rd St.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death.....years.....months.....days. In place of residence.....years.....months.....days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH (Month) June (Day) 26 (Year) 1950

4 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to....., 19.....

I last saw h.er alive on June 25, 1950, death is said to have occurred on the date stated above, at 1:10 A m.

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) uremia

ANTECEDENT CAUSES Due To (b) chronic nephritis

Due To (c)

OTHER SIGNIFICANT CONDITIONS Senility with arteriosclerosis

Major findings:
Of operations.....

Date of operation.....Was autopsy performed?.....

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Josephine D. Cable M. D.
(Address) 42 Whitcomb St. Marlboro Date June 26 1950

6 Immaculate Conception Marlboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL June 28 1950

7 NAME OF FUNERAL DIRECTOR William M Tighe
ADDRESS Marlboro Mass

Received and filed June 27 1950
Francis C Rabbitt
(Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX Female | 9 COLOR OR RACE White | 10 SINGLE, MARRIED, WIDOWER, or DIVORCED (write the word) Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Ambrose W Fitzgerald
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years.....Months.....Days | If under 24 hours .....Hours.....Minutes

13 Usual Occupation Housewife
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City or State or country) Marlboro Mass

PARENTS

17 NAME OF FATHER John O'Connell

18 BIRTHPLACE OF FATHER (City or State or country) Ireland

19 MAIDEN NAME OF MOTHER Bridget Kelleher

20 BIRTHPLACE OF MOTHER (City or State or country) Ireland

21 Informant Julia Fitzgerald Daughter
(Address) Marlboro Rd Southboro Mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P Stone M.D.
(Signature of Agent of Board of Health or other)

Agent, Board of Health
(Official Designation)

June 26 1950
(Date of Issue of Permit)

JUNE FBS.

100M-(C)-10-48-24658

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 12a

1 PLACE OF DEATH

Middlesex (County)

Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Ellen Byrne (nee Downey)
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Cliford St. St. Southboro, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 2 days. In place of residence 40 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH July 14, 1950
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from July 12, 1950, to July 14, 1950

I last saw her alive on July 13, 1950, death is said to have occurred on the date stated above, at 7:40 A.M.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Coronary thrombosis	3 days
ANTECEDENT CAUSES Due To (b) Arteriosclerosis	?
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings:
Of operations.....
Date of operation..... Was autopsy performed?.....
What test confirmed diagnosis? Electrocardiogram

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify.....
(Signed) Timothy P. Stone, M.D. M. D.
(Address) Southboro, Mass. Date 7/14/50 19....

6 Rural Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL July 17, 1950 19....

7 NAME OF FUNERAL DIRECTOR William M. Tighe
ADDRESS Marlboro, Mass.

Received and filed August 12 1950
John F. Roberts
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Myles Byrne
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 73 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Dunbar, Scotland
(State or country)

PARENTS

17 NAME OF FATHER Cannot learn

18 BIRTHPLACE OF FATHER (City) Cannot learn
(State or country)

19 MAIDEN NAME OF MOTHER Cannot learn

20 BIRTHPLACE OF MOTHER (City) Cannot learn
(State or country)

21 Informant Thomas Byrne
(Address) 191 Weston Rd., Wellesley

A TRUE COPY
ATTEST: Francis J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED July 17, 1950 19....

FORM R-301A

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH

do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

The Commonwealth of Massachusetts

EDWARD J. CRONIN, SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 13

1 PLACE OF DEATH: Middlesex (County); Southville (City or Town); No. Parkerville Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Lulu Jane (Thayer) Bussell
(If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parkerville Rd. St. Southville, Mass.
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 22 years ..... months ..... days. In place of residence 22 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH 7/21/50 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from March, 1947, to July, 1950

I last saw her alive on July 21, 1950, death is said to have occurred on the date stated above, at 2:30 p. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary Thrombosis	Sudden
ANTECEDENT CAUSES Due To (b) Coronary Sclerosis	?
Due To (c) Generalized Arteriosclerosis	?
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? No.

What test confirmed diagnosis?.....

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify.....
(Signed) [signature] M. D.
(Address) Walpole, Mass. Date 7/22 1950

6 Wildwood Cemetery Ashland, Mass
Place of Burial or Cremation (City or Town)
DATE OF BURIAL 7/23/50 19

7 NAME OF FUNERAL DIRECTOR Seymour O. Wood
ADDRESS 15 Church St. Hopkinton, Mass

Received and filed July 25, 1950
[signature] (Registrar)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Female	White	Married

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of George H. Bussell
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years 5 Months 2 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: at home
(Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No.....

16 BIRTHPLACE (City) Scranton, Pa.
(State or country)

PARENTS

17 NAME OF FATHER Horace Thayer

18 BIRTHPLACE OF FATHER (City) ? Pa.
(State or country)

19 MAIDEN NAME OF MOTHER Lorretta Lewis

20 BIRTHPLACE OF MOTHER (City) ? Pa.
(State or country)

21 Informant George H. Bussell
(Address) Parkerville Rd. Southville

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone M.D.
(Signature of Agent of Board of Health or other)

Agent, Bd of Health July 22, 1950
(Official Designation) (Date of Issue of Permit)

50M-2-49-25666

FORM R-303 A

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING BLACK INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. MEDICAL EXAMINERS should state CAUSE AND MANNER OF DEATH in plain terms, so that it may be properly classified under the International Classification of Causes of Death. See reverse side for extracts from the laws relative to the return of certificates of death.

If deceased was a U. S. War Veteran, G.L. Chap. 46, Section 10, requires physicians to insert a recital to that effect.

50m-(g)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 14

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Newton St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME John H Baker (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT: (Was deceased a U. S. War Veteran, if so specify WAR) World War I

(a) Residence. No. Newton Street St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 27 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH August 5 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Sudden death presumbly
Coronary Thrombosis

5 Accident, suicide, or homicide (specify) .....

Date and hour of injury ..... 19.....

Where did Injury occur? ..... (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? ..... (Specify type of place)

Manner of Injury ..... (How did injury occur?)

Nature of Injury .....

While at work? ..... Was autopsy performed? .....

6 Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Walter F Wadsworth, M. D.

(A dress) Westwood Date Aug 7 19 50

7 Rural Southboro
Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL August 8 1950

8 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS 15 Cutting Ave., Marlboro

Received and filed August 9 1950

John J Rabeau
(City or Town Clerk)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX	10 COLOR OR RACE	11 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

11a If married, widowed, or divorced HUSBAND of Barbara Cronin (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 69 Years 4 Months 28 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Retired laborer (Kind of work done during most of working life)

15 Industry or Business: Metropolitan Water Works

16 Social Security No. None

17 BIRTHPLACE (City) Marlboro (State or country) Mass.

PARENTS

18 NAME OF FATHER Silas Baker

19 BIRTHPLACE OF FATHER (City) Nova Scotia (State or country)

20 MAIDEN NAME OF MOTHER Mary J. Denman

21 BIRTHPLACE OF MOTHER (City) Newfoundland (State or country) Canada

22 Informant Barbara Baker (Address) Newton St., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone M.D.
(Signature of Agent of Board of Health or other)

Agent, Bd of Health
(Official Designation)

August 7, 1950
(Date of Issue of Permit)

EXTRACTS

FROM THE LAWS OF THE

COMMONWEALTH OF MASSACHUSETTS

GOVERNING THE

RETURN OF CERTIFICATES OF DEATH

A physician or registered hospital medical officer shall forthwith, after the death of a person whom he has attended during his last illness, at the request of an undertaker or other authorized person or of any member of the family of the deceased, furnish for registration a standard certificate of death, stating to the best of his knowledge and belief the name of the deceased, his supposed age, the disease of which he died, defined as required by section one, where same was contracted, the duration of his last illness, when last seen alive by the physician or officer and the date of his death. . .Gen. Laws, Chap. 46, Sec. 9.

A physician or officer furnishing a certificate of death as required by the preceding section or by section forty-five of chapter one hundred and fourteen, shall, if the deceased, to the best of his knowledge and belief, served in the army, navy or marine corps of the United States in any war in which it has been engaged, insert in the certificate a recital to that effect, specifying the war, and shall also certify in such certificate both the primary and the secondary or immediate cause of death as nearly as he can state the same. For neglect to comply with any provision of this section, such physician or officer, shall forfeit ten dollars. For the purposes of this section and of sections forty-five, forty-six and forty-seven of said chapter one hundred and fourteen, the word "war" shall include the China relief expedition and the Philippine insurrection, which shall, for said purposes, be deemed to have taken place between February fourteenth, eighteen hundred and ninety-eight and July fourth, nineteen hundred and two, and the Mexican border service of nineteen hundred and sixteen and nineteen hundred and seventeen. G. L. Chap. 46, Sec. 10.

No undertaker or other person shall bury or otherwise dispose of a human body in a town, or remove therefrom a human body which has not been buried, until he has received a permit from the board of health, or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the person died; and no undertaker or other person shall exhume a human body and remove it from a town, from one cemetery to another, or from one grave or tomb other than the receiving tomb to another in the same cemetery, until he has received a permit from the board of health or its agent aforesaid or from the clerk of the town where the body is buried. No such permit shall be issued until there shall have been delivered to such board, agent or clerk, as the case may be, a satisfactory written statement containing the facts required by law to be returned and recorded, which shall be accompanied, in case of an original interment, by a satisfactory certificate of the attending physician, if any, as required by law, or in lieu thereof a certificate as hereinafter provided. If there is no attending physician, or if, for sufficient reasons, his certificate cannot be obtained early enough for the purpose, or is insufficient, a physician who is a member of the board of health, or employed by it or by the selectmen for the purpose, shall upon application make the certificate required of the attending physician. If death is caused by violence, the medical examiner shall make such certificate. If such a permit for the removal of a human body, not previously interred, from one town to another within the commonwealth cannot be obtained early enough for the purpose, the certificate of death made as above provided and in the possession of the undertaker desiring to make such removal shall constitute a permit for such removal; provided, that such body shall be returned to the town from which it was removed within thirty-six hours after such removal, unless a permit in the usual form for the removal of such body has been sooner obtained hereunder. If the death certificate contains a recital, as required by section ten of chapter forty-six, that the deceased served in the army, navy or marine corps of the United States in any war in which it has been engaged, such recital shall appear upon the permit. The board of health, or its agent, upon receipt of such statement and certificate, shall forthwith countersign it and transmit it to the clerk of the town for registration. The person to whom the permit is so given and the physician certifying the cause of death shall thereafter furnish for registration any other necessary information which can be obtained as to the deceased, or as to the manner or cause of the death, which the clerk or registrar may require.—Chap. 114, Sec. 45, G. L. as amended by Chap. 48, Acts of 1927 and Chap. 414, Acts of 1931.

No undertaker or other person shall bury a human body or the ashes thereof which have been brought into the commonwealth until he has received a permit so to do from the board of health or its agent appointed to issue such permits, or if there is no such board, from the clerk of the town where the body is to be buried or the funeral is to be held, or from a person appointed to have the care of the cemetery or burial ground in which the interment is made.....Chap. 114, Sec. 46, G. L., as amended.

Medical examiners shall make examination upon the view of the dead bodies of persons as are supposed to have died by violence, or by the action of chemical, thermal or electrical agents or following abortion, or from diseases resulting from injury or infection relating to occupation, or suddenly when not disabled by recognizable disease, or when any person is found dead.....— General Laws, Chap. 38, Sec. 6., as amended by Chap. 632, Sec. 4, Acts of 1945.

.....The medical examiner certifies the cause and manner of death to the best of his knowledge and belief.

RULES OF PRACTICE

The fulfillment of the purpose of these laws calls for the observance of the following rules of practice:

(1) **Attending physicians** will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) **Board of Health physicians** will certify to such deaths only as those of persons who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

(3) **Medical Examiners** will investigate and certify to all deaths supposably due to injury. These include not only deaths caused directly or indirectly by traumatism (including resulting septicemia), and by the action of chemical (drugs or poisons) thermal, or electrical agents, and deaths following abortion, but also deaths from disease resulting from injury or infection related to occupation, the sudden deaths of persons not disabled by recognized disease, and those of persons found dead.

STATEMENT OF CAUSE OF DEATH

Medical Examiners in certifying to a death will state the cause and manner thereof, and will specify: (1) Under cause the nature of an injury and of its consequences; and (2) under manner the mode of its production together with the circumstances when these are known. For example: "Compound fracture of the femur with ensuing septicemia (gas bacillus) caused by a steam railway accident." "Pistol shot wound of the chest with associated hemorrhage, homicidal." "Asphyxiation by suspension, suicidal." "Syncope while under the influence of ether administered as a surgical anaesthetic." "Fracture of the skull with associated internal injury sustained under circumstances unknown."

If disease or injury was related to occupation, specify. If investigation shows the death to have been due to disease, specify: (1) Under cause its known or presumable nature; and (2) under manner, indicate the circumstances leading to medico-legal inquiry. For example: "Hemorrhage spontaneous of the brain (basal ganglia) (found dead in bed)." "Heart disease, presumably coronary sclerosis. (Sudden death.)"

SPACE FOR ADDITIONAL INFORMATION

DATE OF ENTERING MILITARY SERVICE February 4, 1918

DATE OF DISCHARGE July 30, 1919

RANK, RATING Private

ORGANIZATION AND OUTFIT Company E, 17th Engineer Railway
Att Demob Det 2

SERVICE NUMBER 2491273

from data on Honorable Discharge paper

Timothy P. Stone M.D.
7 August '20 Bd of Health, Southboro, Mass

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

1 PLACE OF DEATH: SUFFOLK (County) BOSTON (City or Town)

BOSTON (City or town making return)

Registered No. 7272 15

No. Peter Bent Brigham Hosp St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William Gordon
(If deceased is a married, widowed or divorced woman, give also maiden name.)
(Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Oakhill Rd St. Fayville
(Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 10 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Aug 25 1950
(Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1950, to Aug 25, 1950

I last saw h im alive on Aug 25, 1950, death is said to have occurred on the date stated above, at 8:15 P m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) Pneumonia lobar	term
Cerebral thrombosis	2das
ANTECEDENT CAUSES Due To (b) Eroded esophageal varices with hemorrhage	3das
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Cholecystitis Duodenal ulcer	5yrs

Major findings: Of operations. none

Date of operation ..... Was autopsy performed? yes

What test confirmed diagnosis? autopsy

5 Was disease or injury in any way related to occupation of deceased? .....
If so, specify.....
(Signed) E Eppinger, M. D.
(Address) PBBH Date 8/26 1950

6 Walnut Grove Cem Danvers
Place of Burial or Cremation (City or Town)
DATE OF BURIAL Aug 29 1950

7 NAME OF FUNERAL DIRECTOR W H Crosby Inc
ADDRESS Danvers

Received and filed Sept. 5 1950
John J. Rabem
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
male	white	widowed

10a If married, widowed, or divorced HUSBAND of Jane D Daniels
(Give maiden name of wife in full)
(or) WIFE of .....
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 83 Years 3 Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Head farmer-retired
(Kind of work done during most of working life)

14 Industry or Business: Danvers State Hosp

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Scotland

PARENTS

17 NAME OF FATHER Charles Gordon

18 BIRTHPLACE OF FATHER (City) (State or country) Scotland

19 MAIDEN NAME OF MOTHER Margaret Black

20 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

21 Informant Mrs Harriett J Turenne
(Address)

A TRUE COPY
ATTEST: Charles H Mackie
(Registrar of City or Town where death occurred)

DATE FILED Aug 29 1950

FORM R-301A

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

To be filed for burial permit with Board of Health or its Agent.

Registered No. 15

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town); No. Latisquama St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Roy Emerald Williams, (If deceased is a married, widowed or divorced woman, give also maiden name.)

PHYSICIAN — IMPORTANT (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Latisquama St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence ..... years 9 months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Oct. 3rd. 1950. (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from August, 1950, to Oct 3, 1950.

I last saw him alive on Oct 2, 1950. death is said to have occurred on the date stated above, at 2 A.m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a)	Acute coronary occlusion	5 minutes
ANTECEDENT CAUSES Due To (b)	Arteriosclerotic heart disease	10 yrs
Due To (c)	Generalized arteriosclerosis.	10 yrs.
OTHER SIGNIFICANT CONDITIONS	Diabetes mellitis.	20 yrs

Major findings: Of operations — Date of operation — Was autopsy performed? No.

What test confirmed diagnosis? —

5 Was disease or injury in any way related to occupation of deceased? No.
If so, specify —

(Signed) William J. Watkins, M. D.
(Address) Marlboro, Mass. Date ..... 19....

6 Oak Hill, Sterling, Mass. Place of Burial or Cremation (City or Town)
DATE OF BURIAL Oct. 5th. 1950. 19....

7 NAME OF FUNERAL DIRECTOR King & Watson
ADDRESS Clinton, Mass.

Received and filed Oct 6 1950
Frances E Roberts (Registrar)

50m-(b)-11-49-990,560

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Esther Dow (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 71 Years 9 Months 24 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Ret. Merchant (Kind of work done during most of working life)

14 Industry or Business: General Store

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Brome, Quebec Canada

PARENTS

17 NAME OF FATHER Richard A. Williams

18 BIRTHPLACE OF FATHER (City) (State or country) Canada

19 MAIDEN NAME OF MOTHER Losie Jane Hunt

20 BIRTHPLACE OF MOTHER (City) (State or country) Canada

21 Informant Mrs. Esther D. Williams
(Address) Latisquama St. Southboro.

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Bd of Health (Official Designation) X-3-1950 (Date of Issue of Permit)

FORM R-301

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 16

1 PLACE OF DEATH: Worcester (County); Southboro (City or Town)

No. Middle Road St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Mary Ann (Shelnut) Hutt (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Middle Road St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 44a years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: Oct (Month) 12 (Day) 1950 (Year)

4 I HEREBY CERTIFY, That I attended deceased from June 10, 19 50, to Oct 12, 19 50

I last saw her alive on Oct 12, 19 50, death is said to have occurred on the date stated above, at 3 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Arteriosclerotic heart disease	15 yrs
ANTECEDENT CAUSES Due To (b) Gen arteriosclerosis	unknown
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? Clotheserupe

5 Was disease or injury in any way related to occupation of deceased? .....

If so, specify.....

(Signed) Walter F Hutt, M. D.

(Address) Upstream Mass Date Oct 12, 1950

6 Rural Southboro
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Oct 14, 1950

7 NAME OF FUNERAL DIRECTOR Sumner L. Gage

ADDRESS 15-21 Cottage Ave., Southboro

Received and filed October 19 1950

John F Rocco (Registrar)

100M-(C)-10-48-24658

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Female	White	Widowed

10a If married, widowed, or divorced
HUSBAND of.....
(Give maiden name of wife in full)
(or) WIFE of Albert E. Hutt
(Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 86 Years 9 Months 18 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife
(Kind of work done during most of working life)

14 Industry or Business: At home

15 Social Security No.....

16 BIRTHPLACE (City) Pleasant Harbor
(State or country) Nova Scotia

PARENTS

17 NAME OF FATHER —— Shelnut

18 BIRTHPLACE OF FATHER (City) Nova Scotia
(State or country)

19 MAIDEN NAME OF MOTHER —— Speakman

20 BIRTHPLACE OF MOTHER (City) Nova Scotia
(State or country)

21 Informant Walter A. Hutt
(Address) Middle Rd., Southboro

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Lindon P. Stone
(Signature of Agent of Board of Health or other)

Agent Bd of Health X-12-50
(Official Designation) (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

CLINTON
(City or town making return)

Registered No. 167

1 PLACE OF DEATH: Worcester (County); Clinton (City or Town)

No. Clinton Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Edwin L. Barrows (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Turnpike Rd., St. Fayville, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence ..... years 2 months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Nov. 18, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 17, 1950, to Nov. 17. 1950

I last saw him alive on Nov. 17. 1950 death is said to have occurred on the date stated above, at 7:00P m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES Due To (b) Diabetes Mellitus

Due To (c)

OTHER SIGNIFICANT CONDITIONS

Major findings: Of operations

Date of operation Was autopsy performed?

What test confirmed diagnosis?

5 Was disease or injury in any way related to occupation of deceased?

If so, specify.

(Signed) Percy H. Jacck M. D.

(Address) 14 Lincoln St. Hudson, Mass. Date 11.18. 1950

6 Mt. Auburn Cambridge
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 20 1950

7 NAME OF FUNERAL DIRECTOR Richard M. Merrill

ADDRESS 1 Pleasant St., Hudson, Mass.

Received and filed January 26 1951

John F. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Male

9 COLOR OR RACE: White

10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

10a If married, widowed, or divorced HUSBAND of Florence H. Hill (Give maiden name of wife in full)

(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 84 Years 1 Months 29 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Silk Manufacturer (Kind of work done during most of working life)

14 Industry or Business: Silk Mfg.

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Kelwanee, Ill

PARENTS

17 NAME OF FATHER S. Otis Barrows

18 BIRTHPLACE OF FATHER (City) (State or country) Conn.

19 MAIDEN NAME OF MOTHER Mary Brown

20 BIRTHPLACE OF MOTHER (City) (State or country) Conn.

21 Informant (Address) Florence (Hill) Barrows Turnpike Rd., Fayville, Mass.

A TRUE COPY ATTEST: Mildred B. Fallon
(Registrar of City or Town where death occurred)

DATE FILED Nov. 21 1950

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

50m-(e)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 17

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Thomas F. Manning (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Southville Road St. Southboro (If nonresident, give city or town and State)
(Usual place of abode)

Length of stay: In place of death ..... years ..... months 10 days. In place of residence 60 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH November 24, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1950, to Nov. 24, 1950

I last saw him alive on Nov. 25, 1950 death is said to have occurred on the date stated above, at 3:30 P. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Cerebral hemorrage	11 das.
ANTE CEDENT CAUSES Due To (b) Hypertension	
Due To (c) Arteriosclerosis	
OTHER SIGNIFICANT CONDITIONS none	

Major findings: Of operations none

Date of operation none Was autopsy performed? no

What test confirmed diagnosis? Clinical diagnosis

5 Was disease or injury in any way related to occupation of deceased? .....

If so, specify no

(Signed) Timothy P. Stone, M. D.

(Address) Southboro Date 11/25 1950

6 St. John's, Hopkinton
Place of Burial or Cremation (City or Town)

DATE OF BURIAL Nov. 27, 1950 19....

7 NAME OF FUNERAL DIRECTOR T. F. Callanan

ADDRESS Hopkinton, Mass.

Received and filed December 7 1950

John J. Rabeni
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Single

10a If married, widowed, or divorced
HUSBAND of ..... (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 69 Years ..... Months ..... Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Painter (Kind of work done during most of working life)

14 Industry or Business: .....

15 Social Security No. 025-18-0968

16 BIRTHPLACE (City) St. Albans, Vermont (State or country)

PARENTS

17 NAME OF FATHER Thomas Manning

18 BIRTHPLACE OF FATHER (City) Ireland (State or country)

19 MAIDEN NAME OF MOTHER Esther Healey

20 BIRTHPLACE OF MOTHER (City) Ireland (State or country)

21 Informant Mrs. Mary Buckley
(Address) Charlestown, Mass.

A TRUE COPY.
ATTEST: .....
(Registrar of City or Town where death occurred)

DATE FILED November 27, 1950

FORM R-301

The Commonwealth of Massachusetts
OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

STANDARD CERTIFICATE OF DEATH

(City or town making return)

Registered No. 18

1 PLACE OF DEATH: Worcester (County) Tayville (City or Town) No. Pleasant St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Elizabeth Ginga (nee Pela Castanza) (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Pleasant St. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 38 years ..... months ..... days. In place of residence ..... years ..... months ..... days.

INSTRUCTIONS FOR MEDICAL CERTIFICATE

In giving CAUSE OF DEATH do not enter more than one cause for each of (a), (b) and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, or complications which caused death.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

Conditions contributing to the death but not related to the disease or condition causing death.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH: December (Month) 2 (Day) 1950 (Year)

4 I HEREBY CERTIFY, That I attended deceased from November 11, 1950, to December 2, 1950

I last saw h.. alive on December 2, 1950, death is said to have occurred on the date stated above, at 1.30 p. m.

		INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	(a) Pulmonary Embolus	1 hour
ANTECEDENT CAUSES	(b) Due To Thrombophlebitis of left lower leg	6 days
	(c) Due To Acute myocarditis with congestive heart failure	3 weeks
OTHER SIGNIFICANT CONDITIONS	Essential Hypertension	5 yrs.

Major findings: Of operations.....

Date of operation..... Was autopsy performed? no

What test confirmed diagnosis? Physical examination

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify.....

(Signed) Peter P. Coltone, M. D.

(Address) 76 W. Main St. Date Dec 3, 1950

6 Burial Place of Burial or Cremation: Rural (City or Town) Southboro

DATE OF BURIAL Dec 5 1950

7 NAME OF FUNERAL DIRECTOR Wm M. Tighe

ADDRESS Marlboro Mass

Received and filed December 5 1950

John J Rabeni (Registrar)

100M-(C)-10-48-24658

PERSONAL AND STATISTICAL PARTICULARS

8 SEX: Female

9 COLOR OR RACE: White

10 SINGLE MARRIED WIDOWED or DIVORCED (write the word): Widowed

10a If married, widowed, or divorced HUSBAND of..... (Give maiden name of wife in full) (or) WIFE of Ercole Ginga (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 70 Years 2 Months 21 Days. If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Housewife (Kind of work done during most of working life)

14 Industry or Business:.....

15 Social Security No. none

16 BIRTHPLACE (City) (State or country) Italy

PARENTS

17 NAME OF FATHER Louis Pela Castanza

18 BIRTHPLACE OF FATHER (City) (State or country) Italy

19 MAIDEN NAME OF MOTHER can not be learned

20 BIRTHPLACE OF MOTHER (City) (State or country) Italy

21 Informant (Address) Ercole Ginga Pleasant St Tayville mass

I HEREBY CERTIFY that a satisfactory standard certificate of death was filed with me BEFORE the burial or transit permit was issued:

Timothy P. Stone (Signature of Agent of Board of Health or other)

Agent, Board of Health (Official Designation) Dec 4, 1950 (Date of Issue of Permit)

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with unfading black ink — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 19

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town); No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Herbert Pendleton (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Winter St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months 1 days. In place of residence 54 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 16, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1950 to Dec. 16, 1950

I last saw him alive on Dec. 16, 1950 death is said to have occurred on the date stated above, at 10:45 p. m.

	INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Coronary thrombosis	min.
ANTECEDENT CAUSES Due To (b) Rupture arteriosclerotic aneurysm of abdominal aorta	24 hrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS Hypertension	20 yrs.

Major findings: As above
Of operations
Date of operation 6/16/50 Was autopsy performed? yes
What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) Eugene A. Gaston, M.D., M. D.
(Address) Framingham, Mass Date 12/16/50

6 Rural Cemetery - Southboro
Place of Burial or Cremation (City or Town)
DATE OF BURIAL December 19, 1950

7 NAME OF FUNERAL DIRECTOR Sumner C. Gage
ADDRESS Colling Ave., Marlboro

Received and filed Jan 4 1951
John L. Baker
(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced
HUSBAND of Vera Harding (Give maiden name of wife in full)
(or) WIFE of (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 54 Years 11 Months 18 Days | If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Maintenance man (Kind of work done during most of working life)

14 Industry or Business: Women*s Reformatory

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER George Pendleton

18 BIRTHPLACE OF FATHER (City) (State or country) Belfast, Maine

19 MAIDEN NAME OF MOTHER Grace Gleddell

20 BIRTHPLACE OF MOTHER (City) (State or country) Southboro, Mass.

21 Informant Herbert Pendleton, Jr.
(Address) Winter St., Southboro

A TRUE COPY
ATTEST: Wm. J. Walsh
(Registrar of City or Town where death occurred)

DATE FILED December 19, 1950

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with unfading black ink — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 20

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME James P. Eccles (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Sears Road St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death 2 years ... months ... days. In place of residence 40 years ... months ... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 17, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1950, to Dec. 17, 1950

I last saw him alive on Dec. 17, 1950 death is said to have occurred on the date stated above, at 5:15 p.m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
(a) AS heart disease with complete block (A-V)	2 yrs.
ANTECEDENT CAUSES Due To (b) AS heart disease	12 yrs.
Due To (c)	
OTHER SIGNIFICANT CONDITIONS	

Major findings: Of operations ... Date of operation ... Was autopsy performed? no

What test confirmed diagnosis? ECG

5 Was disease or injury in any way related to occupation of deceased? no If so, specify ...

(Signed) Hugh Folsom, M.D. (Address) Framingham, Mass. Date 12/18/50

6 St. Bernards Cemetery-Concord Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 20, 1950

7 NAME OF FUNERAL DIRECTOR James H. Dee

ADDRESS 13 Bedford St., Concord

Received and filed Jan 9, 1951

John J. Rabbini (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE MARRIED WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced. HUSBAND of Delia J. O'Toole (Give maiden name of wife in full)

(or) WIFE of ... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 72 Years 2 Months 12 Days | If under 24 hours ... Hours ... Minutes

13 Usual Occupation: Caretaker (Kind of work done during most of working life)

14 Industry or Business: Gardener

15 Social Security No. ...

16 BIRTHPLACE (City) (State or country) Madison, Scotland

PARENTS

17 NAME OF FATHER John Eccles

18 BIRTHPLACE OF FATHER (City) (State or country) Scotland

19 MAIDEN NAME OF MOTHER Jessie Pedigrew

20 BIRTHPLACE OF MOTHER (City) (State or country) Scotland

21 Informant Mrs. Delia Eccles (Address) Sears Road, Southboro

A TRUE COPY ATTEST: Wm. A. Walsh (Registrar of City or Town where death occurred)

DATE FILED December 19, 1950

FORM R-302

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-302 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(b)-11-49-900,475

The Commonwealth of Massachusetts

EDWARD J. CRONIN
SECRETARY OF THE COMMONWEALTH
DIVISION OF VITAL STATISTICS

COPY OF CERTIFICATE OF DEATH

Framingham (City or town making return)

Registered No. 71

1 PLACE OF DEATH: Middlesex (County); Framingham (City or Town)

No. Framingham Union Hospital St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Charles Henry Newton (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Lyman St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years 2 months ..... days. In place of residence 82 years ..... months ..... days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH December 28, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1950, to Dec. 28, 1950

I last saw him alive on Dec. 27, 1950, death is said to have occurred on the date stated above, at 2:30AM m.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) Carcinoma Rectum — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES Due To (b)

Due To (c)

OTHER SIGNIFICANT CONDITIONS Liver Metastasis

Major findings: Of operations: As Above

Date of operation ..... Was autopsy performed? yes

What test confirmed diagnosis? Autopsy

5 Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) Eugene A. Gaston M. D.

(Address) Framingham, Mass. Date 12/28/50 19

6 Rural Cemetery Southboro, Mass. Place of Burial or Cremation (City or Town)

DATE OF BURIAL December 30, 1950 19

7 NAME OF FUNERAL DIRECTOR Summer C. Gage

ADDRESS Marlboro, Mass.

Received and filed Jan. 9 19 51

John J. Rabeni

(Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

8 SEX	9 COLOR OR RACE	10 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word)
Male	White	Married

10a If married, widowed, or divorced HUSBAND of Agnes Cowern (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

11 IF STILLBORN, enter that fact here.

12 AGE 82 Years 1 Months 3 Days — If under 24 hours ..... Hours ..... Minutes

13 Usual Occupation: Supt. (Retired) (Kind of work done during most of working life)

14 Industry or Business: Dairy Business

15 Social Security No.

16 BIRTHPLACE (City) (State or country) Southboro, Mass.

PARENTS

17 NAME OF FATHER Adoniran Newton

18 BIRTHPLACE OF FATHER (City) (State or country) Marlboro, Mass.

19 MAIDEN NAME OF MOTHER Caroline Arnold

20 BIRTHPLACE OF MOTHER (City) (State or country) Marlboro, Mass.

21 Informant Mr. A. Spurr (Address) Southboro, Mass.

A TRUE COPY ATTEST: Wm. J. Walsh (Registrar of City or Town where death occurred)

DATE FILED Dec. 29, 1950 19

FORM R-305

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING BLACK INK — THIS IS A PERMANENT RECORD

Copies of returns of deaths which occurred in your city or town in case the deceased resided in another city or town at the time of death should be transmitted on Form R-305 to the clerk of the city or town in which the deceased resided as soon as possible after the close of the month in which the death occurred. (See Chap. 46, Sec. 12, G. L.)

25m-(h)-10-48-24658

The Commonwealth of Massachusetts

OFFICE OF THE SECRETARY
DIVISION OF VITAL STATISTICS

COPY OF MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Natick (City or town making return)

Registered No. 92

1 PLACE OF DEATH: Middlesex (County); Natick (City or Town)

No. Worcester Turnpike - Natick St. (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME William G. Mitchell (If deceased is a married, widowed or divorced woman, give also maiden name.) (Was deceased a U. S. War Veteran, if so specify WAR)

(a) Residence. No. Parker St. Southboro, Mass. (Usual place of abode) (If nonresident, give city or town and State)

Length of stay: In place of death ..... years ..... months ..... days. In place of residence 10 years — months — days.

MEDICAL CERTIFICATE OF DEATH

3 DATE OF DEATH Dec. 29, 1950 (Month) (Day) (Year)

4 I HEREBY CERTIFY that I have investigated the death of the person above-named and that the CAUSE AND MANNER thereof are as follows: (If an injury was involved, state fully.)

Multiple Injuries

Automobile Accident

5 Accident, ~~suicide, or homicide (specify)~~

Date and hour of injury 12/29/50 8 A.M.

Where did Injury occur? Natick, Mass. (City or town and State)

Did injury occur in or about home, on farm, in industrial place, or in public place? Main Highway (Specify type of place)

Manner of Injury Crushed by auto truck (How did injury occur?)

Nature of Injury Multiple Fractures & wounds

While at work? on way to Was autopsy performed? view

6 Was disease or injury in any way related to occupation of deceased? .....

If so, specify .....

(Signed) M. F. Burke, M. D.

(Address) Natick Date Dec. 30 19 50

7 Rural Southboro Place of Burial, or Cremation. (City or Town)

DATE OF BURIAL Jan. 1, 19 51

8 NAME OF FUNERAL DIRECTOR A. H. Doherty

ADDRESS Natick

Received and filed Jan 9 19 51

Francis E. Roberts (Registrar of City or Town where deceased resided)

PERSONAL AND STATISTICAL PARTICULARS

9 SEX: M.

10 COLOR OR RACE: W.

11 SINGLE, MARRIED, WIDOWED or DIVORCED (write the word): Married

11a If married, widowed, or divorced HUSBAND of Dorothy E. Frye (Give maiden name of wife in full)

(or) WIFE of ..... (Husband's name in full)

12 IF STILLBORN, enter that fact here.

13 AGE 38 Years 5 Months 21 Days | If under 24 hours ..... Hours ..... Minutes

14 Usual Occupation: Model Coil Winder (Kind of work done during most of working life)

15 Industry or Business:

16 Social Security No. 021- 05- 0177

17 BIRTHPLACE (City) (State or country) Boston Mass.

PARENTS

18 NAME OF FATHER Alexander Mitchell

19 BIRTHPLACE OF FATHER (City) (State or country) Quincy Mass.

20 MAIDEN NAME OF MOTHER Alice A. Gagnon

21 BIRTHPLACE OF MOTHER (City) (State or country) Pepperell Mass.

22 Informant Dorothy E. Mitchell (Address) Cordaville

A TRUE COPY. ATTEST: Francis E. Roberts (Registrar of City or Town where death occurred)

DATE FILED Jan. 3, 19 51